Mia Blomquist L.Ac.
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650-474-9477
www.bohofamilywellness.com

Welcome! Thank you for chosing to work with me on your journey towards better health. It is an honor to be chosen as your practitioner and together we will improve your diet, make necessary lifestyle changes and find the root cause of what ails you so that true healing can take place.

You're sessions are very important to me. Please consider travel time when coming to the office and allow yourself at least 5-10 minutes to settle in and relax before your actual appointment. I do have a 24 hour cancelation policy. If you need to cancel before 24 hours, please still let me know. I can often fill the appointement time and save you the cancellation fee. The cancellation policy for new patients is 48-hours.

The first visit is 90 minutes. We will do a full health history and exam, talk about your chief complaints and lifestyle, and perform the first acupuncture treatment. Return visits are 60 minutes. Please have a little something in your stomach before coming. If you happen to be coming to the office on an empty stomach please let me know.

I look forward to meeting you and helping you achieve physical, emotional and spiritual well being!

Warmly,
Mia B.

PATIENT INFORMATION (Please Print and complete in full)

Name: _____ Today's Date:_____

Address:_____

_____

Home# : _____Work#:_____Mobile#:_____

Email Address: _____

Sex: Female Male Trans Other

Patient Status: Married Single Divorced Widowed Other

Birth Date:_____ Age: ____ Social Security #_____

Referred to our Clinic By:
_____

Emergency Contact: _____Relationship: _____

Emergency Contact Telephone #:
_____

Employment Status:
Full Time Part Time Retired Unemployed Student Military

Occupation:
_____

Employer's Name:
_____

Physician's Name:_____Telephone #:_____

Informed Consent for Treatment

I consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine performed by Mia Blomquist and her associates. I have discussed the nature and purpose of my treatment with the Licensed Acupuncturist.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (Chinese Massage), Chinese herbal medicine, and nutritional counseling. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, such as bruising, fainting, numbness or tingling.

The herbs and nutritional supplements (which are derived from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs are inappropriate during pregnancy, or for those with high blood pressure. I will notify my practitioner of ANY and ALL drugs and/or supplements I take. I will also notify my practitioner immediately of any side effects from herbs or supplements prescribed.

I will notify the Acupuncturist who is caring for me if I am or become pregnant, or if I have, or develop a heart condition.

I do not expect the Licensed Acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment, which the Licensed Acupuncturist thinks at the time, based upon the facts then known, is in my best interest.

I understand the Licensed Acupuncturist may review medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, this consent to treatment form, have been told about the risks and benefits of acupuncture and other procedures, and have had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient (or patient representative If the patient is a minor or is physically or legally incapacitated).

Date_____

Print Name of Patient_____

Signature of Patient X_____

Name of Patient Representative_____

Signature of Patient Representative_____

****All Patient Information is strictly confidential. Our office is HIPPA compliant****
If you would like further information regarding patient rights please ask us.

Patient Name:_____

Briefly describe what brings you in today:

_____

Have you ever had an acupuncture treatment? When and for what reason?

_____

Are you presently being treated for a medical condition? Please describe:
_____

Please briefly describe any chronic pain:

_____

Please briefly explain any hospitalizations/surgeries:
_____

Please list all western medications and dosage:
_____

Are there any other areas of your health that you are concerned about or wish to improve?

Please describe the type of foods you eat regularly:

Breakfast _____
Morning Snack_____
Lunch_____
Afternoon Snack_____
Dinner_____
Evening Snack_____

Do you exercise regularly? Yes No
What type of exercise do you do?
_____

Coffee:_____
Alcohol/Drug use:_____

History of Trauma:_____

Credit Card Information

We ask to keep your credit card information on file to secure your appointments. We will never charge your credit card without giving you notice beforehand. You will be charged the full rate for missed appointments without 24- hour notice.

Patient name_____
Date_____
Credit card number_____
Expiration date on card_____
Security code_____
Name on card_____

VISA M/C AMEX DISCOVER

Notes: _____

_____

SYMPTOMS – NOTE: For each symptom you currently have, rate severity from 1-5 (5 being the worst).

Liver/Gallbladder
___Irritability/Anger
___Depression/Stress
___Headaches/Migraines
___Visual Problems
___Red/Dry/Itchy Eyes
___Gallstones
___Dizziness
___Blurred Vision
___Feeling a Lump in Throat
___Feeling a Lump in Throat
___Muscle Cramping/Twitching
___Tension
___Joints/Neck/Shoulder Pain
___Poor Circulation
___Soft/Brittle Nails
___Bad taste
___Bad breath
___Craves sour

Kidney/Urinary Bladder
___Urinary Problems
___Bladder infections
___Prolapsed Bladder
___Incontinence/Lack of bladder control
___Weakness or Pain in low back
___Decreased bone density
___Feels Cold Easily
___Cold Hands/Feet
___Low/Excessive Sex Drive
___Poor Memory
___Loss of Hair
___Hearing Problems
___Cavities
___Frequent Fear
___Hot Flashing/Night Sweats
___Craves Salty

Spleen/Stomach
___Difficult to get up in the AM
___Muscles often feel tired
___Edema(swelling)/Bloating
___Difficulty digesting
___Abdominal Pain
___Feeling of heaviness in body
___Fatigue on scale of 1(low) to 10 (high)
___Easily Bruise and/or Bleed
___Nausea/vomiting/gas/belching
___Constipation or Diarrhea
___Hemorrhoids (internal or external)
___Tendency to over-think things
___Tendency to Gain Weight
___Foggy thinking or brain fog
___Craves Sweet

Heart/Small Intestine
___Heart Palpitations
___Chest Pain/Shortness of breath
___Insomnia/Sleep Problems
___Restlessness/Agitation
___Vivid Dreams
___Craves Bitter
___Anxiety

Lung/Large Intestine
___Dry/ Productive Cough
___Nasal Discharge (Circle Color) Clear, green, yellow
___Post Nasal Drip
___Dry Mouth/Throat/Nose
___Skin Rashes/Hives
___Grief/Sadness
___Allergies/Asthma
___Poor resistance to Colds/Flus
___Constipation, IBS, Colitis, Diarrhea
___Craves Pungent
___Snoring
___Itchy throat