Red Bamboo Medicine ☯ Tamara Ja, L.Ac.
3116 Adeline Street, #128. Oakland, CA 94608
(415) 515-0332 ☯ Tamara@redbamboomedicine.com ☯ www.redbamboomedicine.com

Please complete this form as thoroughly as possible and bring it with you to your first appointment. While some of these questions may seem unrelated and unnecessarily detailed, they are important to diagnose your overall condition and may affect your treatment. All information will be kept strictly confidential.

**Personal Information**

| Date | First Name | | Last Name | | Middle initial |
|---|---|---|---|---|---|
| Date of birth | Exact time of birth | Age | Gender | Height | Weight |
| Street Address | | | City | State | Zip Code |
| Mobile Phone | | | Home Phone | | |
| Email | | | Emergency Contact (Name & Number) | | |
| How did you hear about Red Bamboo Medicine? | | | | | |

| Primary Physician | Physician Phone |
|---|---|
| Physician Office Address | |

| Insurance Company | Insurance Company Address & Phone Number |
|---|---|
| Name of policy holder (if not yourself) | Relationship to you |
| Insured ID number | Policy Group or FECA Number |
| Social Security Number | |
| Employment Status (Circle one)<br><br>Full time \| Part time \| Self Employed \| Retired \| Unemployed \| Student | |

**Treatment History – If you need more space, please use the back of this form.**

| |
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| What issue(s) would you like to address? |
| Summarize the history of the above issue(s) – include duration, frequency, exacerbation and alleviation. |
| Have you been treated previously for the above issue(s)? If so, please describe. |
| Have you had acupuncture before? If so, for what condition(s)? |
| Have you taken Chinese herbs before? If so, for what condition(s)? |
| Have you had a Reiki treatment before? If so, for what condition(s)? |
| Are you currently being treated for any other condition(s)? If so, please describe. |
| Please list and briefly describe any other health concerns you have. |

**Diet & Exercise – Please describe your typical daily diet.**

| | |
|---|---|
| Breakfast:<br><br>Lunch: | Dinner:<br><br>Snacks: |
| Average daily fluid intake (# glasses/day), please also list what you typically drink. | |
| Please briefly describe how often you eat out vs. how often you cook at home. | |
| Are you currently on a special diet? (e.g., vegan, vegetarian, gluten-free, low carb, candida-diet) | |
| Please list any known food allergies. | |
| Do you exercise? Please describe and include frequency. | |

**Medications**

Please list all medications you are currently using. Also list those you are no longer using at this time but have used for an extended period of time within the past 6 months. If you need more space, please use the back of this page.

| Name | Purpose | Dosage | Frequency | Began use (approx) | Last dose taken |
|---|---|---|---|---|---|
| | | | | | |
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**Supplements, Vitamins, Herbs**

Please list all dietary, nutritional, vitamin and herbal supplements you are currently using.

| Name | Purpose | Dosage | Frequency | Began use (approx) | Last dose taken |
|---|---|---|---|---|---|
| | | | | | |
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| Please list any known drug or herb allergies. | | | | | |

Please note usage of the following. Leave blank if not applicable.

| | Amount/day or week | Describe |
|---|---|---|
| Caffeinated coffee | | |
| Caffeinated tea | | |
| Alcohol | | |
| Cigarettes | | |
| Marijuana | | |
| Other drugs | | |

**Personal Medical History**

- Write a “C” for current problem
- Write a “P” for past problem
- Leave blank if not applicable
- Please list current age of relatives or approximate age when they passed on

| | | You | Mother | Father | Sister(s) | Brother(s) | Children |
|---|---|---|---|---|---|---|---|
| | Age | | | | | | |
| AIDS/HIV | | | | | | | |
| Alcohol | | | | | | | |
| Allergies | | | | | | | |
| Anxiety | | | | | | | |
| Anorexia/Bulimia | | | | | | | |
| Arthritis | | | | | | | |
| Asthma | | | | | | | |
| Back issues | | | | | | | |
| Bursitis | | | | | | | |
| Cancer (specify): | | | | | | | |
| Candida | | | | | | | |
| Constipation | | | | | | | |
| Depression | | | | | | | |
| Diabetes | | | | | | | |
| Digestive issues | | | | | | | |
| Drug addiction | | | | | | | |
| Headaches/Migraines | | | | | | | |
| Heart issues | | | | | | | |
| Hepatitis | | | | | | | |
| High blood pressure | | | | | | | |
| IBS/Crohn’s disease | | | | | | | |
| Immune disorder | | | | | | | |
| Insomnia | | | | | | | |
| Kidney issues | | | | | | | |
| Liver issues | | | | | | | |
| Neck issues | | | | | | | |
| Skin issues (specify): | | | | | | | |
| STDs (specify): | | | | | | | |
| Thyroid issues | | | | | | | |
| Tobacco | | | | | | | |
| Tuberculosis | | | | | | | |
| Weight issues | | | | | | | |
| Other: | | | | | | | |

**Menstrual/GYN history. If you need more space, please use the back of this page.**

| |
|---|
| Are your menstrual cycles regular? If no, please describe and note average length of cycle. |
| Please describe your average length of menstrual flow (include initial days of spotting). |
| Please describe your average amount of flow (circle one): heavy \| average \| light |
| Menstrual cramps (circle all that apply): none \| before menses \| after menses \| during menses<br>Please indicate severity. |
| Please describe duration of cramps (hours/days). |
| Please describe any other PMS symptoms (e.g. bloating, headaches, irritability, breast distension). |
| History of miscarriage (Y/N)?<br>Circle one: Before 3 months After 3 months<br>How many? |
| History of abortion (Y/N)?<br>How many? |
| Do you currently use contraception? If so, please describe. |
| Please briefly describe your previous contraception history and note duration of use for each. |

**Symptoms**

- For current symptoms, rate the severity from 1-5 (5 being the most severe)
- For past symptoms, check or circle P
- Leave blank if not applicable

Liver / Gallbladder

| Severity | Symptom |
|---|---|
| [1] [2] [3] [4] [5] [P] | Irritability / Anger |
| [1] [2] [3] [4] [5] [P] | Depression |
| [1] [2] [3] [4] [5] [P] | Stress / Tension |
| [1] [2] [3] [4] [5] [P] | Headaches / Migraines |
| [1] [2] [3] [4] [5] [P] | Red / Dry / Itchy Eyes |
| [1] [2] [3] [4] [5] [P] | Blurred / Poor Night Vision |
| [1] [2] [3] [4] [5] [P] | Dizziness |
| [1] [2] [3] [4] [5] [P] | Gallstones |
| [1] [2] [3] [4] [5] [P] | Feeling of Lump in Throat |
| [1] [2] [3] [4] [5] [P] | Teeth Clenching at Night |
| [1] [2] [3] [4] [5] [P] | Muscle Cramp / Twitch |
| [1] [2] [3] [4] [5] [P] | Pain / Tight in Joints / Muscles |
| [1] [2] [3] [4] [5] [P] | Rib / Flank Pain or Distension |
| [1] [2] [3] [4] [5] [P] | Poor Circulation |
| [1] [2] [3] [4] [5] [P] | Soft / Brittle Nails |
| [1] [2] [3] [4] [5] [P] | Emotional Eating |
| [1] [2] [3] [4] [5] [P] | Bad / Sour Taste in Mouth |
| [1] [2] [3] [4] [5] [P] | Craving Sour Foods |

Kidney / Urinary Bladder

| Severity | Symptom |
|---|---|
| [1] [2] [3] [4] [5] [P] | Fear |
| [1] [2] [3] [4] [5] [P] | Urinary Problems |
| [1] [2] [3] [4] [5] [P] | Bladder Infection |
| [1] [2] [3] [4] [5] [P] | Incontinence |
| [1] [2] [3] [4] [5] [P] | Weak / Pain in Low Back |
| [1] [2] [3] [4] [5] [P] | Decreased Bone Density |
| [1] [2] [3] [4] [5] [P] | Feeling Cold Easily |
| [1] [2] [3] [4] [5] [P] | Cold Hands |
| [1] [2] [3] [4] [5] [P] | Cold Feet |
| [1] [2] [3] [4] [5] [P] | Low Libido (Sex Drive) |
| [1] [2] [3] [4] [5] [P] | Excess Libido (Sex Drive) |
| [1] [2] [3] [4] [5] [P] | Poor Memory |
| [1] [2] [3] [4] [5] [P] | Premature Graying of Hair |
| [1] [2] [3] [4] [5] [P] | Premature Loss of Hair |
| [1] [2] [3] [4] [5] [P] | Hearing Problems |
| [1] [2] [3] [4] [5] [P] | Cavities |
| [1] [2] [3] [4] [5] [P] | Hot Flashes / Night Sweats |
| [1] [2] [3] [4] [5] [P] | Craving Salty Foods |

Spleen / Stomach

| | |
|---|---|
| [1] [2] [3] [4] [5] [P] | Body Heaviness |
| [1] [2] [3] [4] [5] [P] | Fatigue |
| [1] [2] [3] [4] [5] [P] | Difficulty Getting Up in Morning |
| [1] [2] [3] [4] [5] [P] | Muscle Weakness / Tired |
| [1] [2] [3] [4] [5] [P] | Edema (swelling) |
| [1] [2] [3] [4] [5] [P] | Easy to Bruise / Bleed |
| [1] [2] [3] [4] [5] [P] | Bad Breath |
| [1] [2] [3] [4] [5] [P] | Nausea / Vomiting |
| [1] [2] [3] [4] [5] [P] | Difficulty Digesting Fatty Foods |

Lung / Large Intestine

| | |
|---|---|
| [1] [2] [3] [4] [5] [P] | Dry Cough |
| [1] [2] [3] [4] [5] [P] | Productive Cough |
| [1] [2] [3] [4] [5] [P] | Bloody Cough |
| [1] [2] [3] [4] [5] [P] | Nasal Discharge |
| [1] [2] [3] [4] [5] [P] | Post Nasal Drip |
| [1] [2] [3] [4] [5] [P] | Sinus Congestion |
| [1] [2] [3] [4] [5] [P] | Itchy / Red / Painful Throat |
| [1] [2] [3] [4] [5] [P] | Skin Rash / Hives |
| [1] [2] [3] [4] [5] [P] | Snoring |

[1] [2] [3] [4] [5] [P] Gas / Belching

[1] [2] [3] [4] [5] [P] Hemorrhoids

[1] [2] [3] [4] [5] [P] Constipation

[1] [2] [3] [4] [5] [P] Loose Stools

[1] [2] [3] [4] [5] [P] Abdominal Pain

[1] [2] [3] [4] [5] [P] Heartburn / Indigestion

[1] [2] [3] [4] [5] [P] Over-Thinking

[1] [2] [3] [4] [5] [P] Tendency to Gain Weight

[1] [2] [3] [4] [5] [P] “Foggy” Brain

[1] [2] [3] [4] [5] [P] Craving Sweet Foods

Heart / Small Intestine

[1] [2] [3] [4] [5] [P] Heart Palpitations

[1] [2] [3] [4] [5] [P] Chest Pain

[1] [2] [3] [4] [5] [P] Insomnia / Sleep Problems

[1] [2] [3] [4] [5] [P] Easily Startled

[1] [2] [3] [4] [5] [P] Restless / Vivid Dreams

[1] [2] [3] [4] [5] [P] Craving Bitter Foods

[1] [2] [3] [4] [5] [P] Grief / Sadness

[1] [2] [3] [4] [5] [P] Shortness of Breath

[1] [2] [3] [4] [5] [P] Allergies

[1] [2] [3] [4] [5] [P] Asthma

[1] [2] [3] [4] [5] [P] Low Resistance to Colds

[1] [2] [3] [4] [5] [P] Sneezing

[1] [2] [3] [4] [5] [P] Mild Fever

[1] [2] [3] [4] [5] [P] Emphysema

[1] [2] [3] [4] [5] [P] Bronchitis

[1] [2] [3] [4] [5] [P] Constipation

[1] [2] [3] [4] [5] [P] Irritable Bowel Syndrome

[1] [2] [3] [4] [5] [P] Colitis / Spastic Colon

[1] [2] [3] [4] [5] [P] Diarrhea

[1] [2] [3] [4] [5] [P] Craving Spicy Foods

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**INFORMED CONSENT TO TREATMENT**

I hereby request and consent to the performance of acupuncture and other procedures associated with Traditional Chinese Medicine by Tamara Ja, L.Ac. I have had the opportunity to discuss the nature and purpose of my treatment with the above named practitioner.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese or Western herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but occasionally it may have side effects, including bruising, numbness or tingling near the needling sites that may last for a few days and dizziness or fainting. Bruising is a common side effect of cupping. Burns and/or scarring are a potential risk of moxibustion. Rare and unusual risks of acupuncture include infection, spontaneous miscarriage, nerve damage, organ puncture, and pneumothorax. I understand that while this document describes the major risks of treatment, other possible side effects may occur.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Traditional Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some herbs may have an unpleasant smell or taste. Possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes and tingling of the tongue. If I experience any gastro-intestinal upset or allergic reactions to the herbs I will inform Tamara Ja, L.Ac.

I will notify Tamara Ja, L.Ac., if I am or become pregnant.

I do not expect Tamara Ja, L.Ac. to be able to anticipate and explain all possible risks and complications of treatment and I wish to rely on the above named acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interest.

I understand the clinical and administrative staff may review my 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, the above consent. I have been told about the risks and benefits of acupuncture and other procedures and have had an 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.

| | |
|---|---|
| _____ | _____TAMARA JA, L.Ac_____ |
| Print Name of Patient (or Representative) | Print Name of Practitioner |
| X_____ | X_____ |
| Signature of Patient (or Representative) | Signature of Practitioner |