Kokko Wellness

Patient Informed Consent Agreement:

I agree to receive acupuncture treatments and related therapies by John Kokko, L.Ac. Treatment methods may include, but are not limited to, acupuncture, Tui-Na massage and bodywork, cupping therapy, herbal medicine, nutritional supplements, heat and moxibustion therapy, electro-stimulation, physiotherapy exercises, as well as lifestyle and nutrition counseling.

I have been informed that acupuncture is very safe, but it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and in rare cases dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture. Infection is also a possible risk. However, I understand that John Kokko, L.Ac. uses only sterile disposable single-use needles, and maintains a clean and safe environment. Tui-Na massage therapy is very safe but may lead to temporary muscle soreness, redness, or bruising. Burns and scarring are potential risks of heat or moxibustion therapy. Bruising is a common side effect of cupping.

The herbs and nutritional supplements used in Traditional Chinese Medicine are considered safe but may have potential side effects. I understand that some herbs may be toxic at large doses, and some herbs may be inappropriate to take during pregnancy. I will notify John Kokko, L.Ac., immediately if I notice any unanticipated or unpleasant side effects associated with the consumption of herbal medicine or nutritional supplements.

I do not expect John Kokko, L.Ac. to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on him to exercise judgment during the course of treatment to make decisions that are in my best interest, based upon the facts then known.

I understand that the clinical and medical staff may review my files but all my records will be kept confidential and can only be released under my personal written consent, or when required by law.

Kokko Wellness is actively attempting to mitigate the risk of viral & microbial transmission. However, I understand that if I do contract any type of infection, Kokko Wellness and its staff will not be held liable.

Treatment includes approximately 10 minutes of fully-clothed bodywork after needles are removed. This portion of the treatment is completely optional. If you would like to opt-out of bodywork, please do so by informing our staff and checking the appropriate box:

☐ **I would like to receive bodywork** ☐ **I would like to opt-out of bodywork**

If I am unable to make a pre-scheduled appointment, I agree to cancel <u>at least 24 hours in advance.</u> I understand that failure to do so will result in my being **charged $50**. I also understand that if I am more than 15 minutes late to an appointment, the remainder of the time-slot may be given to another client.

By voluntarily signing below, I show that I have read (or have had read to me) and understood this consent to treatment. I have been told about the risks and benefits of acupuncture and related therapies and have had an opportunity to ask questions. This consent form shall cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment from John Kokko, L.Ac.

_____	**<u>John Kokko, L.Ac.</u>**
Print Name of Patient (and Representative)	**Print Name of Practitioner**
X_____	_____
Patient Signature / Date	**John Kokko, L.Ac.**

Kokko Wellness
HEALTH HISTORY

Date: ____ / ____ / _____

Name:	Sex:	Age:

Address:	City:	State:	Zip Code:

Home Phone #:	Other Phone #: Work Cell Other	Email:

Date of Birth:	Employer:	Occupation:

Health Care Providers:

Relationship Status: ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed ❒ Living w/partner ❒ Other: _____

Height:	Usual Blood Pressure:

Weight:	Weight One Year Ago:	How did you hear of our clinic?

Are you or may you be currently pregnant?

Have you been treated by Acupuncture or Oriental Medicine Before?
❍ No ❍ Yes: when _____/_____/_____

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

2 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

3 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

HEALTH HISTORY

Check the ❒ if you have / had the condition and note the year it started.
Check the ❍ if there is a family history of the condition.

	YOU	Year	FAMILY
Cancer type(s)? _____	❒	_____	❍
Diabetes	❒	_____	❍
Hepatitis	❒	_____	❍
High Blood Pressure	❒	_____	❍
Heart Disease	❒	_____	❍
Stroke	❒	_____	❍
Seizure Disorder	❒	_____	❍
Thyroid Disease	❒	_____	❍
Asthma	❒	_____	❍
Pacemaker	❒	_____	❍
Osteoporosis	❒	_____	❍
Herpes	❒	_____	❍
AIDS / HIV	❒	_____	❍
Other STD	❒	_____	❍
Rheumatic Fever	❒	_____	❍
Alcoholism	❒	_____	❍
Allergies type(s)? _____	❒	_____	❍
Mental Illness	❒	_____	❍
Kidney Disease	❒	_____	❍
Anemia	❒	_____	❍

HABITS

	Amount / Week	If Quit, Year?
Coffee / Tea	_____	_____
Soda	_____	_____
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____

EXERCISE

Do you exercise regularly? ⑤ Yes ⑤ No
If so, what and how often:

_____
_____
_____

DIET

Low/No Carb, Vegetarian/Vegan, Portion Control, Low Fat, Standard American

Current or past eating disorder?

MEDICATIONS

Please note what medications, herbs or supplements that you take regularly

_____
_____
_____

INJURIES & SURGERIES

Please note what happened to what body area and when it occurred (incl. dental)

_____
_____
_____

HEALTH HISTORY

Please mark an X on the scales and check any boxes of symptoms you have had in the past month

TEMPERATURE

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

COLD ——— HOT

- ❒ Cold hands or feet
- ❒ Chills
- ❒ Cold "in the bones"
- ❒ Areas of numbness

Thirst for cold / hot drinks
- ❒ Thirst, no desire to drink
- ❒ Absence of thirst
- ❒ Excessive thirst

- ❒ Night sweats
- ❒ Unusual sweats
  When_____ am / pm
  Where on body _____ _

- ❒ Hot hands, feet, chest
- ❒ Hot flashes
- ❒ Hot in afternoon
- ❒ Hot at night

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY ——— OILY

- ❒ Dry skin
- ❒ Dry hair
- ❒ Dry eyes
- ❒ Dry brittle nails

- ❒ Dry mouth
- ❒ Dry lips
- ❒ Dry throat
- ❒ Dry nose / Nosebleeds

Where on your body?
- ❒ Edema / Swelling _____
- ❒ Rashes _____
- ❒ Itching _____
- ❒ Dandruff

- ❒ Oily skin
- ❒ Oily hair
- ❒ Pimples
- ❒ Weight gain / loss

DIGESTION

DIARRHEA ——— CONSTIPATION

BM: How often? _____x / every _____days
Stools keep shape? ❒ Y ❒ N
- ❒ Alternating diarrhea & constipation (IBS)
- ❒ Indigestion

- ❒ Gas
- ❒ Bloating
- ❒ Belching
- ❒ Poor appetite

- ❒ Nausea / Vomiting
- ❒ Bad breath
- ❒ Heartburn
- ❒ Excessive hunger

- ❒ Dry Stools
- ❒ Difficult to pass
- ❒ Tired after BM
- ❒ Foul smelling stools

ENERGY

LOW ——— HIGH

- ❒ Sudden energy drop
  Time of day: _____ am / pm
- ❒ Energy drop after eating
- ❒ Fatigue

- ❒ Dependence on caffeine / stimulants
- ❒ Wired / ungrounded feeling
- ❒ Body / Limbs feel heavy
- ❒ Body / Limbs feel weak

- ❒ Shortness of breath
- ❒ Heart Palpitations
- ❒ Blood pressure High / Low
- ❒ Bleed / Bruise easy

- ❒ Hard to concentrate
- ❒ Poor memory
- ❒ Dizziness / lightheaded
- ❒ Headaches _____x / week

SLEEP

Hours per night _____
- ❒ Difficulty falling asleep
- ❒ Wake ___x/ night @_____am / pm
- ❒ Wake to urinate: How often? _____
- ❒ Disturbing dreams
- ❒ Restless sleep
- ❒ Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?

- ❒ Anger
- ❒ Irritability
- ❒ Anxiety
- ❒ Worry
- ❒ Obsessive thinking
- ❒ Sadness
- ❒ Grief
- ❒ Depression
- ❒ Joy
- ❒ Fear
- ❒ Timid / shy
- ❒ Indecision

EYES, EARS, NOSE, THROAT

- ❒ Poor vision
- ❒ Night blindness
- ❒ Red eyes
- ❒ Itchy eyes
- ❒ Spots in front of eyes
- ❒ Sinus congestion
- ❒ Phlegm (color_____)
- ❒ Poor hearing
- ❒ Ringing in ears
- ❒ Excess earwax
- ❒ Sore throat
- ❒ Dental problems
- ❒ Mouth sores
- ❒ Cough

MENSES

Age at first menses: _____
Length of full cycle: _____ days (i.e. 28)
Length of menses: ____ days (i.e. 3-4)
Last menses start date: ____ / ____
# of pregnancies: ____
# of births: _____ premature _____
# of abortions / miscarriages: _____

- ❒ Heavy periods
- ❒ Light periods
- ❒ Painful periods
- ❒ Irregular periods
- ❒ Changes in body/ psyche prior to menstruation (PMS)

- ❒ Cramps
  - ❒ Before bleeding
  - ❒ First day
  - ❒ During period
- ❒ Clots
- ❒ Breast tenderness

- ❒ Mood changes
- ❒ Fatigue w/ menses
- ❒ Digestive changes w/ menses
- ❒ Mid-cycle spotting
- ❒ Yeast infections
- ❒ Birth control pill (hormonal)

MENOPAUSE

Age at last menses: _____
Year changes began: _____

- ❒ Hot flashes _____x / day
- ❒ Night sweats _____x / week

- ❒ Vaginal dryness
- ❒ Loss of sex drive

Name _____ Date _____

Food Intake

Please tell us what your typical meals and snacks look like, and what time you eat it.
Don't forget coffee, teas, sodas, alcohol, juices, etc.

Time of Day	What You're Eating
Breakfast	
Snacks	
Lunch	
Snacks	
Dinner	
Snacks	

Which type of food tastes do you prefer? (circle) sweet salty spicy sour bitter

Which type of food tastes do you dislike? (circle) sweet salty spicy sour bitter

How many cups (8 oz) of water/juice do you drink per day? _____

Kokko Wellness **John Kokko, L.Ac.** Name _____ Date _____

Medications (please list)

Name	Current Use?	Dates used	Dosage	Reason
	yes / sometimes / no			
	yes / sometimes / no			
	yes / sometimes / no			
	yes / sometimes / no			
	yes / sometimes / no			
	yes / sometimes / no			

Supplements

Type	Current Use?	Brand name	Dosage	Reason
Multi Vitamins	yes / sometimes / no			
Vit B^{12} or B-complex	yes / sometimes / no			
Vit D^{3}	yes / sometimes / no			
Vit C	yes / sometimes / no			
Iron	yes / sometimes / no			
Calcium/Magnesium	yes / sometimes / no			
Omega 3	yes / sometimes / no			
CoQ10	yes / sometimes / no			
Antioxidants	yes / sometimes / no			
Probiotics	yes / sometimes / no			
Digestive Aids	yes / sometimes / no			
Green Powder	yes / sometimes / no			
Energy Drinks/Products	yes / sometimes / no			
Joint Health	yes / sometimes / no			
Weight Loss	yes / sometimes / no			
Muscle Building	yes / sometimes / no			
Protein Powder	yes / sometimes / no			
Other	yes / sometimes / no			

Herbs and Teas

Name	Current Use?	Dates used	Dosage	Reason
	yes / sometimes / no			
	yes / sometimes / no			

Name _____ Date _____

Special Considerations

Is there anywhere on your body that you would like us to avoid during treatment? Any old injuries? Psychological considerations? History of trauma?

Are there any considerations of cultural, religious, or spiritual practices that you would like to let us know about?