Dr. Hughes's Holistic Wellness Center

4343 Concourse Dr. Suite 170, Ann Arbor, MI, 48108
P: (734) 905-0318 | F: (253) 234-1376 | www.DrHughesHolisticCenter.com

Today's date _____/_____/_____
Month / Day / Year

Name (First, MI, Last)			Social Security No.(last 4 digits only) XXX-XX-_____	Date of Birth _____/_____/_____ Month / Day / Year
Age	Sex ◯ M ◯ F	Marital Status ◯ S ◯ M ◯ D ◯ W	Email Address	Home Phone (_____) _____ - _____
Home Address (street, city, state and zip code) _____ _____ _____				Work Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____
Employer			Job Title /Occupation	Fax (_____) _____ - _____
Emergency Contact (Name)			Contact (Phone) (_____) _____ - _____	Who referred you?

Personal Physician (Name and Address)	Preferred Pharmacy Name/Phone
_____ _____ _____ Office phone number: (_____) _____ - _____	_____ _____ _____ Pharmacy phone number: (_____) _____ - _____

Best way to contact you (Choose One): ☐Home Phone ☐Work Phone ☐Cell Phone

Do we have permission to leave the following information on an answering machine or voice mail?

Appointment Information: ◯NO ◯YES, these #'s: ☐Home ☐Work ☐Cell ☐Other _____
Medical Information: ◯NO ◯YES, these #'s: ☐Home ☐Work ☐Cell ☐Other _____
Billing/Payment Information: ◯NO ◯YES, these #'s: ☐Home ☐Work ☐Cell ☐Other _____

If someone answers the phone when we call, who can we leave this information with?

☐ No One
☐ Spouse _____ ☐ Child(ren) _____
☐ Friend _____ ☐ Other _____

Minor Patient Section

If the patient is a minor, is he/she accompanied by a legal guardian?
◯ If **Yes**: Must bring a valid photo ID
◯ If **No**: Each adult to accompany the minor must bring
1) a completed Permission to Accompany Minor Form
2) copies of their own and the guardian's valid photo IDs

_____ _____ _____/_____/_____
Legal Guardian's Signature: Print Legal Guardian's Name: Date:

_____ _____ _____/_____/_____
Patient's Signature: Print Patient's Name: Date:

Complaints/Concerns

Please list ***in order of importance,*** **the five (5) main concerns you have (starting with the most important one**).
Please note how long each symptoms has been present.

Problem	Onset	Frequency	Mild	Moderate	Severe	Previous Treatments / Approach	Results? Excellent	Good	Fair
0. e.g. Headaches	6 / 2007	4 times / week							
1.			☐	☐	☐		☐	☐	☐
2.			☐	☐	☐		☐	☐	☐
3.			☐	☐	☐		☐	☐	☐
4.			☐	☐	☐		☐	☐	☐
5.			☐	☐	☐		☐	☐	☐

What do you hope to achieve in your visits with us?

_____
_____
_____

If you had a magic wand and could erase three health problems or symptoms, which would they be, and why?

1. _____
2. _____
3. _____

When was the last time you felt well? _____
Did something trigger your change in health? _____
What makes you feel **worse**? _____
_____
What makes you feel **better**? _____
_____

Please list all physicians you have seen for the above health conditions:

1.	4.
2.	5.
3.	6.

Please check all the Alternative Treatments you have tried for your condition(s)

☐ None	☐ Massage	☐ Yoga	☐ Environmental medicine
☐ Chiropractic	☐ Rolfing	☐ Hypnosis	☐ Dietary Therapy
☐ Acupuncture	☐ Reiki	☐ Ayurveda	☐ Biological Dentistry
☐ Supplements	☐ Homeopathy	☐ Light therapy	☐ IV (intravenous) therapy
☐ Colonics	☐ Biofeedback	☐ Meditation	☐ Naturopathic medicine
☐ _____	☐ _____	☐ _____	☐ _____

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Acupuncture Therapy Informed Consent

I hereby request and consent to the performance of treatments within the scope of Traditional Chinese Medicine (TCM) on me (or on the patient named below for whom I am legal guardian) by Dr. Ann Hughes M.D. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, TDP lamp, cupping, electrical stimulation, and herbs; I also give Dr. Hughes permission to use health information about my treatment for possible medical research or publication, without my name.

I understand that acupuncture is a generally safe method of treatment, but that may occasionally cause a drop of blood to appear after the needle is withdrawn (which is treated with direct pressure) or even create bruising at the needles site. Dizziness may occur as can nausea or lightheadedness and these reactions resolve with change of position or removal of the needles (I understand that it is best not to be too hungry before receiving an acupuncture treatment and to inform Dr. Hughes if I suffer from "needle phobia".) All of these reactions are very rare. Bruising is common with cupping, and TDP lamp or moxibustion can cause burns and/or scarring very rarely. Infection is always a risk with the use of needles, but this is minimized in acupuncture by using sterile, disposable needles; and it is almost never seen with acupuncture treatments. Sensations such as soreness, numbness, tingling, electrical sensations, or heaviness are a normal response to the needles and indicate that the acupuncture is working. I agree to inform Dr. Hughes immediately should any of these incidents occur.

Herbal remedies that are used in TCM are traditionally considered safe, particularly herbal combinations or "patent" formulas. It is important that these be taken in accordance with Dr. Hughes's instructions. Side effects are uncommon, but can include nausea, vomiting, or diarrhea. If any side effects should occur, I agree to contact Dr. Hughes as to the appropriate course of action. I also understand that some herbs or acupuncture points may be inappropriate during pregnancy. I agree to notify Dr. Hughes if I become pregnant during treatment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I do not expect Dr. Hughes to be able to anticipate and explain all possible risks and side effects. I understand that results are not guaranteed. I understand that is important for me to disclose my health history and present condition to Dr. Hughes and this information will be kept confidential.

In accordance with current privacy laws, I further understand that TCM is in no way the practice of medicine; and if I require medical treatment, I will seek out the appropriate professional.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, 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.

PATIENT SIGNATURE (or patient representative, indicate relationship if signing for patient)

Patient/Guarantor Name (Printed)	Patient/Guarantor Signature	Date