

Nicholas A. Shirghio, A.P. LLC
3811 Airport Road North
Naples, Florida 34105
239-777-7063

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition. Thank you.

Personal Information

Name _____ Age _____ Date _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

SS Number _____ E-mail _____

Birth date _____ If under 18, person responsible for your account _____

Emergency Contact: Name _____ Contact Phone: _____

Whom should we thank for referring you to our office? _____

Have you had acupuncture therapy before? Yes No With Whom? _____

Please indicate if any of the following pertain to you: (marking "yes" does not make you ineligible for treatment, however, it may restrict some of our treatment modalities):

Hepatitis HIV High Blood Pressure Seizures Pacemaker Blood-Thinning Meds Pregnancy

Please indicate the use and frequency of the following:

Coffee _____ Soda pop _____ Water _____

Alcohol _____ Recreational drugs _____ Tobacco _____

Please list any prescription or over-the-counter medications you are presently taking:

Medication	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Health History

What are the health problems for which you are seeking treatment? _____

How long have you had this condition? _____

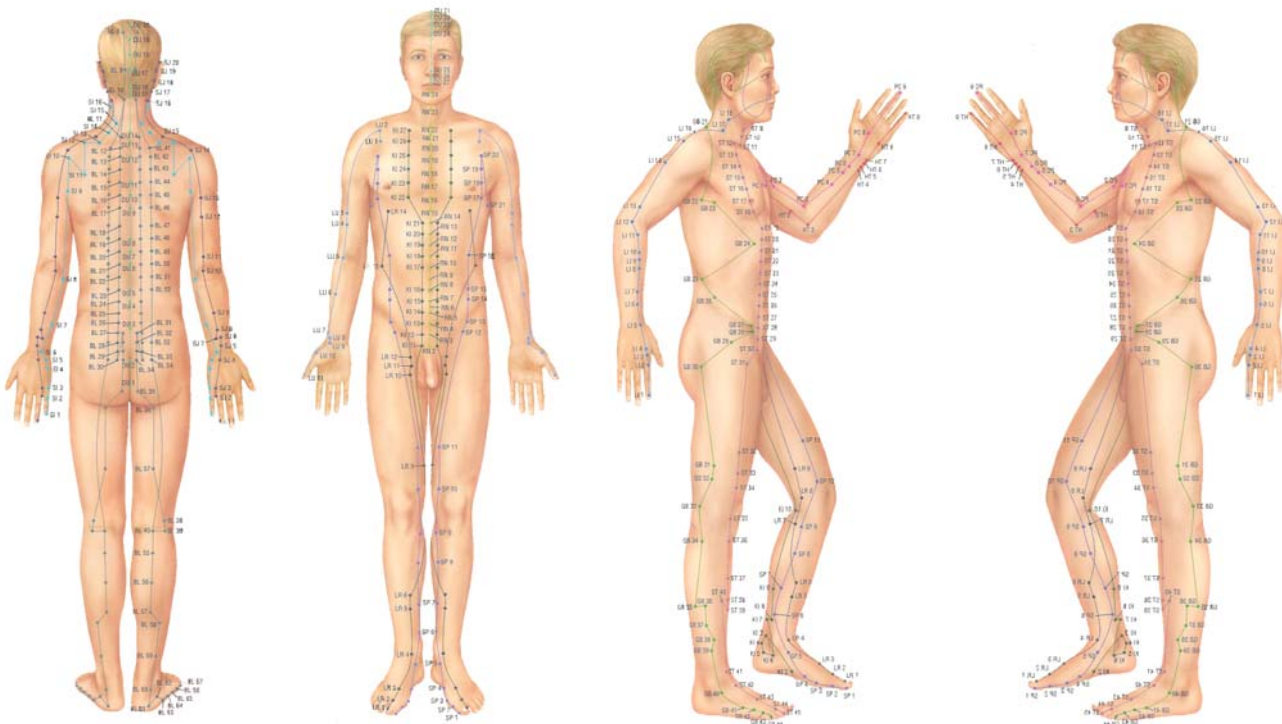
What other forms of treatment have you sought? _____

What helps your condition? _____

What aggravates your condition? _____

Please list any surgeries or major health incidents (accidents, etc.) in your life: _____

PAIN PATIENTS, please indicate on the figures below the areas of the body you experience your pain:



How would you characterize your pain: dull/achy sharp/stabbing burning tingling numbness electrical

What would you like to achieve with acupuncture treatment? _____

NICHOLAS A. SHIRGHIO, A.P. DOM.

Airport Professional Center
 3811 Airport Road North
 Suite # 206
 Naples, Florida 34105

239-777-7063

On a scale of 1-10, rate your commitment to get rid of the problem(s) and feel better _____ Any concerns or fears about the needles? _____ If yes, what _____ What are your goals of your acupuncture visits? 1. _____ 2. _____	MEDICAL CONDITIONS Please List conditions & surgeries you have had		ALLERGIES Medications, Seasonal, Environmental, food.

SYMPTOMS - * NOTE *: For each Symptom you currently have, rate its severity from 1- 5 (5 being the worst). LEAVE BLANK IF NOT APPLICABLE.

LIVER / GALLBLADDER

- _____ Irritability / Anger
- _____ Depression / Stress
- _____ Headaches / Migraines
- _____ Visual Problems
- _____ Red / Dry / Itchy Eyes
- _____ Gall Stones
- _____ Dizziness
- _____ Blurred Vision
- _____ Feeling of Lump in Throat
- _____ Clenching of Teeth at Night
- _____ Muscle Cramping / Twitching
- _____ Tension
- _____ Joints / Neck / Shoulder / Pain
- _____ Poor Circulation
- _____ Soft / Brittle Nails
- _____ Emotional Eater

KIDNEY / URINARY BLADDER

- _____ Urinary Problems
- _____ Bladder Infection
- _____ Lack of Bladder Control
- _____ Weakness / Pain in Lower Back
- _____ Decrease Bone Density
- _____ Feel Cold Easily
- _____ Low Sex Drive
- _____ Excess Sexual Desire
- _____ Poor Memory
- _____ Loss of Hair
- _____ Hearing Problems
- _____ Cavities
- _____ Craving/ Avoiding Salty Foods
- _____ Fear
- _____ Hot Flush / Night Sweating

HEART/SMALL INTESTINES

- _____ Heart Palpitations
- _____ Chest Pain
- _____ insomnia / Sleep Problems
- _____ Easily Startled
- _____ Restlessness / Agitation
- _____ Vivid Dreams
- _____ Lack of Joy in Life

LUNG /LARGE INTESTINE

- _____ Dry Cough
- _____ Cough with Sputum
- _____ Nasal Discharge
- _____ Post-Nasal Drip
- _____ Sinus Infection / Congestion
- _____ Itchy, Red or Painful Throat
- _____ dry Mouth / Throat / Nose
- _____ Skin Rashes / Hives
- _____ Snoring
- _____ Grief/ Sadness
- _____ Shortness of Breath
- _____ Allergies / Asthma
- _____ Low Resistance to Colds or Flu
- _____ Sneezing
- _____ Mild Fever Comes & Goes
- _____ Smoke Cigarettes

SPLEEN/STOMACH

- _____ Heaviness Anywhere in Body
- _____ Fatigue / Worse After Eating
- _____ Hard to Get Up in the Morning
- _____ Edema (Swelling)
- _____ Muscles Feel Tired Often
- _____ Easily Bruising & Bleeding
- _____ Bad Breath
- _____ Decreased / Increased Appetite
- _____ Crave Sweets
- _____ Hypoglycemia
- _____ Difficulty Digesting Oily Foods
- _____ Nausea / Vomiting
- _____ Gas / Belching
- _____ Insulin Sensitivity
- _____ Hemorrhoids
- _____ Constipation
- _____ Diarrhea
- _____ Abdominal Pain
- _____ Indigestion / Heartburn
- _____ Over-Thinking
- _____ Tendency to Gain Weight
- _____ Brain Foggy

Informed Consent to Treatment

I request and consent to the performance of the treatments on myself, or the patient named below, for whom I am legally responsible, by Nicholas A. Shirghio, A.P. LLC., who now or in the future will treat me. The treatment techniques are acupuncture and other oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, heat and/or cold therapy and electrical and/or magnetic stimulation, cupping, electro acupuncture, acupuncture injection therapy, vitamin injections, prolo-puncture, prolo-therapy, shihatsu, and/or moxibustion; Laser Acupuncture and the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle counseling.

I understand I have an opportunity to discuss with Nicholas A. Shirghio, A.P. LLC. the nature and purpose of acupuncture and oriental medical procedures. Although I am aware that acupuncture and the other procedures used in oriental medicine have helped many people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I have been informed and understand that in the practice of oriental medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are a possibility. I understand that these risks include, but are not limited to: slight bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted or radiating from that location, nerve pain, minor burns, aggravation of current symptoms, appearance of new symptoms, and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect Nicholas A. Shirghio, A.P. LLC. to be able to anticipate and explain all risks and complications, and I will rely on him as my practitioner to exercise his judgment during the course of my treatment, based on the facts known then, to be in my best interest.

I have read, or have had read to me, this informed consent form. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I understand that this consent form is intended to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from Nicholas A. Shirghio, A.P. LLC Acupuncture Center.

Patient's name (please print)

Patient's signature

Patient's Representative (if applicable)

Relationship or Authority of Representative

Signature of Patient's Representative (if applicable)

Date Signed