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____________

SS Number______________________________ Cell Phone ______________________________

Home Phone__________________________ E-mail______________________________

Birthdate____________________ 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? ______________________________

____

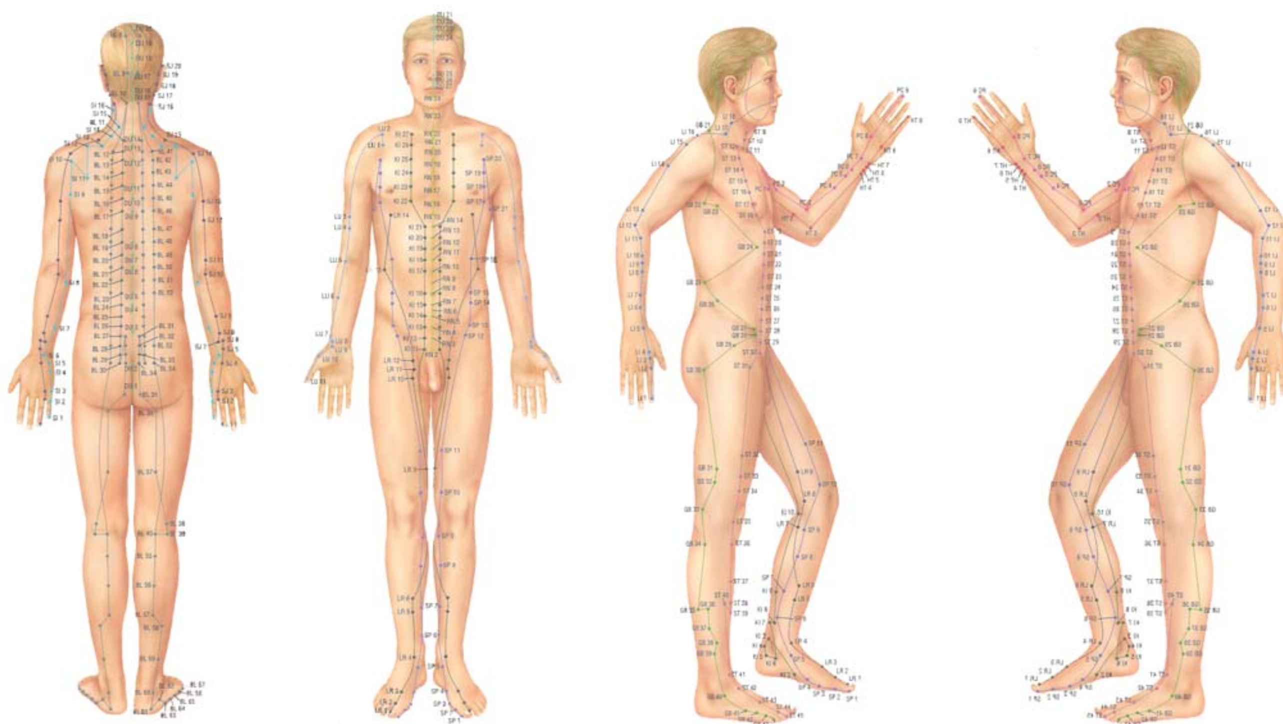
What helps your condition? ______________________________

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

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. ____________________
3. ____________________

	MEDICAL CONDITIONS Please List conditions & surgeries you have had and year diagnosed.	1 ALLERGIES Medications, Seasonal, Environmental, Food.

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

LI VER / GALLBLADDER

_____ Irritability / Anger
_____ Depression / Stress
_____ Headaches / Migraines
_____ Visual Problems
_____ Red / Dry / Itchy Eyes
_____ Gall Stones
_____ Dizziness
_____ Blurred Vision
_____ Feeling of Lu m p in Throat
_____ Clenching of Teeth at Night
_____ Muscle Cra m ping / Twitching
_____ Tension
_____ Joints/Neck/Shoulder Pain/Tight
_____ Poor Circulation
_____ Soft / Brittle Nails
_____ E m otional Eater

KIDNEY/ URINARY BLADDER

_____ Urinary Proble m s
_____ Bladder Infection
_____ Lack of Bladder Control
_____ Weakness / Pain in Lower Back
_____ Decrease Bone Density
_____ Feel Cold Easily
_____ Low Sex Drive
_____ Excess Sexual Desire
_____ Poor Me m ory
_____ Loss of Hair
_____ Hearing Proble m s
_____ 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 Sputu m
_____ 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 / Asth m a
_____ Low Resistance to Colds or Flu
_____ Sneezing
_____ Mild Fever Co m es & Goes
_____ S m oke Cigarettes

SPLEEN/STOMA CH

_____ Heaviness Anyv~ere 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
_____ Hypoglyce m ia
_____ Diff~culty Digesting Oily Foods
_____ Nausea / Vo m iting
_____ Gas / Belching
_____ Insulin Sensitivity
_____ He m orrhoids
_____ Constipation
_____ Diarrhea
_____ Abdo m inal 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, 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