124 Pearl Street Suite 301

Ypsilanti, Michigan, 48197

Phone: 734 383 6583 **Website:** http://www.oriental-rose.net **Email:** information@oriental-rose.net

New patient information form

(Please print clearly)

Legal Given (First) Name:	**Legal Middle Name:**	**Legal Surname (Last Name):**
Preferred Name:		**Date of Birth:**
Gender : Please circle	Male Female	Third Gender Intersex
Martial Status: Please circle	Married Widowed Partnership Polyamorous	Single Divorced Seperated Other
Street address:		**City:**
State:		**Zip code:**
Home Phone:	**Cell Phone:**	**Email Address:**
Occupation:	**Ocupational stresses:** (Chemical, physical, emotional)	

Emergency contact details	
Name of friend or relative	**Relationship to you:**
Address:	**Contact number:**

Have you ever been diagnosed with the following?		(Please add the specific condition and the year diagnosed)
Allergies:	Epilepsy	Pelvix Inflamatory Disease
Asthma	Epstein Barr	Rheumatic Fever
AIDS/HIV	Glaucoma	Scoliosis
Arthritis	Heart Disease	Seizures
Anemia:	Herpes:	Thyroid Disease
Cancer:	Hepatits:	Tuberculosis
Cornoary Artery Disease	High Blood Pressure	**PACEMAKER**
Crohn's / IBS (please circle)	Mental Illness	Other:
COPD:	Multiple Sclerosis	Other:
Diabetes:	Osteoporosis	Other:

Please list your prescibed medications, over the counter medications and vitamins		
Medication- Dose - Frequency Taken	**Duration (how many months/years)**	**Prescribing Physician**

Please list any allergies to medications or food and the specific reaction:

The above information is true to the best of my knowledge.

I understand that I am financially responsible for payment to Oriental Rose LLC at the time services are rendered.

I authorize Oriental Rose LLC to contact me at the above phone number, postal and email addresses in relation to continued treatment and appointments.

I hereby authorize Dr. Rose Noonan, Lac DiplAc, to furnish Acupuncture, Massage, Moxibustion, Gua Sha, Cupping Therapy and/or various other therapeutic treatments.

Signed:_____ **Date:**_____

Cupping Therapy

It has been explained to me, and I understand that cupping therapy may leave bruise-like marks that will last several days to several weeks depending on the severity of my condition. While most marks fade and disappear after a few days, there are times when marks could take up to 15 days to clear and in rare cases, it has been reported that marks have taken up to 21 days to fully clear. These areas of bruising or discoloration are typically not painful, but can on occasion have soreness, itching and there may be soreness in the surrounding muscles. Cupping therapy is a medical treatment, not a novelty and should be treated accordingly. Your acupuncture physician will determine which areas are most appropriate for cupping, which type of cupping methods should be used and where how many cups should be applied, the length of time the cups should remain on and which cupping techniques (stationary, moving, etc.) to employ. This is not a service in which the patient should expect to dictate the terms of the service such as in a massage service.

Fire cupping - On rare occasions blisters my occur, either from the heat or from fluids being drawn to the surface by the cups and on occasion, however unlikely, a patient may experience a burn from the heated cups or heating implement. Small blisters should be left alone to heal on their own, while larger blister should be drained and dressed by the acupuncturist.

I understand that cupping treatments can be a “detoxifying” treatment process and as a result, I may feel nauseous or unwell following treatment. Drinking water and taking Vitamin C has been reported to relieve these symptoms quickly. In some cases headaches and minor body aches may be experienced.

Contraindications

- Hemophilia or other bleeding/clotting disorders
- Patients taking blood thinners
- Weak patients or those who have been ill.
- Abdomen on pregnant women
- Diabetics. Especially those with uncontrolled blood sugar as they may not be able to feel pain properly.
- Those who are unable to experience heat or pain properly
- Those who have circulatory conditions
- Those who are unsure if their condition is contraindicated should seek guidance from their primary care physician prior to receiving cupping therapy.

I _____, understand that bruising, discoloration and/or soreness will likely occur following this treatment and may take days or weeks to fully resolve. I further understand that the above-listed conditions are contraindicated for cupping therapy and I have informed my acupuncturist of any and all medical conditions, even those not listed as contraindications. I further understand that there is a potential for burns and/or blisters due to the fire/heat aspect of the treatment. This is a rare but not unexpected occurrence.

Name (Please print): _____

Signed:_____ **Date:_____**