WELCOME!

Please fill out the information below so we can better serve you. Thank you!

Name _____ Birth Date _____ Sex___F____M____

Street Address _____ City _____State _____Zip_____
Primary Phone _____ Work Phone _____
E-Mail _____ Occupation _____

Emergency Contact _____Relationship _____Phone _____

Primary Physician _____Physician Phone _____

How did you hear about us? _____
Is it okay to send reminders via Email _____or _____Text _____

Are you currently using medication or herbal medicine/supplements? _____Yes _____No
If yes, please list _____
_____

Medical History: Please check all of the following that apply to you currently and in the past.

_____ Arthritis _____ Abortion _____ Abnormal Menses
_____ Allergies – Please specify _____ _____ Anemia
_____ Angina _____ Asthma _____ Artificial Joints
_____ Bleeding Tendency _____ Bronchitis _____Cancer Type_____
_____ Chronic Fatigue _____ Convulsions/Seizures _____ Diabetes
_____ Diarrhea/Constipation _____ Depression/Anxiety _____Emphysema
_____ Excess Thirst _____ Headaches/Migraines _____ Heart Disease
_____ Heartburn _____Hepatitis_____A_____B_____C
_____ High Blood Pressure _____HIV Positive _____ Hypoglycemia
_____ Hospitalizations/Surgical Procedures_____
_____ Herpes _____ Kidney Disease _____ Liver Condition
_____ Osteoporosis _____ Pacemaker ____Palpitations/Arythmia
_____ Peptic Ulcer _____ Pregnant, # of weeks___ _____ Prostrate Problems
_____ Sinusitis _____ Stroke _____ Thyroid Condition
_____ Tobacco Use _____ Other _____

Family History: Please check mark any that apply and explain the relationship.

_____ Cancer_____ _____ Heart Disease_____
_____ Hypertension_____ _____Autoimmune Condition_____
_____ Other_____

Skin History: Please check mark any that apply to you.

_____ Acne _____ Botox
_____ Dry skin _____ Dark circles under eyes _____ Dermal fillers
_____ Face surgeries/procedures _____
_____ Face puffiness _____ Microdermabrasion within the last 6 weeks
_____ Oily skin _____ Rosacea _____ Sensitive skin
_____ Under eye puffiness _____ Under chin puffiness

Please describe your current concern_____
_____

When it began_____
What Treatments have you received for this concern? _____ Surgery _____
_____Medications _____
_____ Facials _____
_____ Nutrition Support _____
_____ Facial Rejuvenation/Cosmetic Acupuncture _____
_____ Other_____

How often are your symptoms present?
____Constant ____Frequent ____Intermittent ____Occasional

Which or the following is part of your lifestyle?
____Tobacco Smoking ____Recreational Drugs ____Exercise
____Coffee Drinking ____Alcohol Drinking ____Birth Control Pills
____High Stress ____Relaxation/Meditation
____Poor Digestion (Gas/bloating/diarrhea/constipation)

Please check which apply to you.
____High Appetite ____Low Appetite _____Artificial Sweeteners/Colors Intake
____Thirst ____Sugar Intake _____Gluten Free
____Dairy Intake ____Soft Drinks Intake _____ Dairy Free
____# of glasses of water/liquid per day

Cancellation Policy – 48 Hour Notice Required

Our mission is to help as many people as possible while offering the highest level of care possible. With respect to these intentions, we **require 48 hours notice** in advance of an appointment if it is necessary to cancel or reschedule. This allows us enough time to contact other patients and fulfill their desire and need for this appointment time.

All appointments that are cancelled or rescheduled with less than 48 hours notice, and appointments missed without notice, will be charged a **cancellation fee of $50.** Thank you for your understanding.

Patient Signature:_____ Date:_____

Printed Name: _____

Acupuncture Consent Form

DISCLAIMER
Informed consent documents are used to communicate information about the proposed treatment along with disclosure of risks and benefits of treatment. The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of the most patients in most circumstances. However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your acupuncturist may provide you with additional or different information, which is based on upon all the facts in your particular case and the present state of knowledge within the field of acupuncture. Informed consent documents are not intended to define or serve as the standard of acupuncture. Standards of acupuncture are determined on the basis of all of the facts involved in an individual case and are subject of change as scientific knowledge and technology advance and as practice patterns evolve.

Please Read the Following:

Acupuncture is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolves with pressure. It is normal for a patient to have a temporary warm, tight, achy or tingling sensation at the acupuncture site. Though uncommon, a hematomas (bruising) may occur at some acupuncture sites as every body's vascular system varies. Please apply arnica and gently rub the area and it should subside in 4-7 days.

Acupressure/Tuina involves rubbing, kneading and/or pressing which may result in muscle soreness that can last for several days.

Indirect Moxa requires burning an herbal material near the skin. Every precaution is taken to prevent skin contact, but the possibility of skin contact and mild burns exists.

Cupping involves a localized suction produced by heating a small glass cup or utilizing a electronic cupping machine. There is a possibility of bruising at the treatment site, which usually subsides in 3-7 days. Tell your practitioner if you are on blood thinners or have a bleeding disorder.

Gua Sha involves scraping over a small area by using a smooth-edged instrument. There is a possibility of local bruising at the site that may last 3-7 days.

Electrical Stimulation uses microcurrent electricity to stimulate acupuncture points. A mild tingling sensation of electricity may be felt.

Infra-red Heat Lamp may be used during a treatment. Every caution is taken in the use of an infra-red lamp, but the possibility of skin contact and mild burns exist, especially if a patient tries to move the lamp themselves.

I have read the above consent and have had the opportunity to ask questions and discuss this with my provider. I consent to the treatment that involves the above procedures for my present condition(s) and any other condition. I have the right to refuse or discontinue any treatment at any time and understand that this refusal may affect the expected results.

I understand that my provider has given me information on the methods of treatments and any side effects that may occur.

_____ _____

Patient Signature Date