CONFIDENTIAL PATIENT INFORMATION

Name: ________________________________ Hm #:_____________________ Cel #________________

Street: ___________________________________ City: _________________ State _________ Zip_______

Date of Birth _____________Age: ____ M __ F __ Ht: ____Wt:_____ Driver's Lic. #___________________

Social Security # _____________________How did you hear about us _______________________________

Primary Reason for your visit today ____

Other concurrent therapies ____

Name of Doctor: __________________________ Phone # _______________ Fax #_______________

Address: ______________________________ City __________________ State_____ Zip Code________

Doctors Diagnosis____

How are you responding to your present course of treatment? Better ______Worse ______ Same _____

In case of Emergency please notify: _________________________ Phone:____________________

Employer: ______________________________ Occupation ____________________________

Employer's address_____________________________ City____________ State_____ Zip Code________

Injured at work?_______ Date of injury_______________ Wk #: _____________________

______________________________ Claim #____________________ __________________________

Primary Insurance Company Insurance phone #

____

Insurance Address City State Zip Code

____

Claim Adjuster's name/Ext #

______________________________ Claim #____________________ __________________________

Secondary Insurance Company Insurance phone #

____

Insurance Address City State Zip Code

I hereby certify that the preceding questions have been answered truthfully to the best of my knowledge and belief.

Patient/Guardian Signature:____________________________ Date:_________________

PATIENT INTAKE FORM

Patient Name:______________________________ **Date:**___________

PAST MEDICAL HISTORY (include dates)
( ) Cancer ( ) Diabetes ( ) Heart Disease ( ) Stroke ( ) Sexually Transmitted Disease ( ) Seizure
( ) Hepatitis ( ) Thyroid Disease ( ) Alcoholism ( ) High Blood Pressure
( ) Other (explain) ____

FAMILY **PAST MEDICAL HISTORY**
( ) Cancer ( ) Diabetes ( ) Heart Disease ( ) Stroke ( ) Sexually Transmitted Disease ( ) Seizure ( ) Hepatitis
( ) Thyroid Disease ( ) Alcoholism ( ) High Blood Pressure ( ) Other (explain) ______________________________

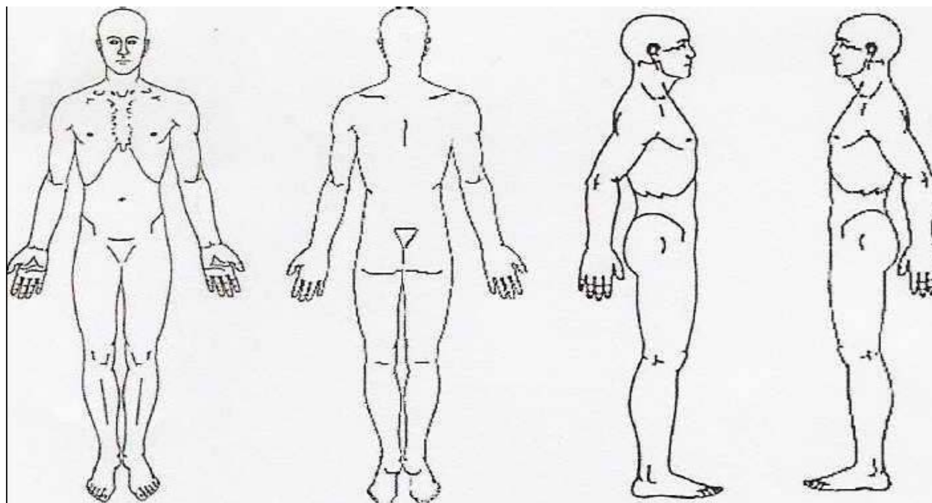
SURGERIES____

ALLERGIES (drug, food, chemical, environmental) ____

MEDICINE taken in the past 2 months (medications, vitamins, and food supplements)
Name
________________________ Dosage ________________________
________________________ Dosage ________________________
________________________ Dosage ________________________
________________________ Dosage ________________________
________________________ Dosage ________________________

MUSCULOSKELETAL (Please indicate on the diagram below):

( ) Neck Pain ( ) Muscle Pain ( ) Back Pain ( ) Joint Pain ( ) Knee Pain ( )Wrist/Hand ( )Ankle/Foot



How would you describe the pain:____

What makes pain worse:____

What makes pain better:____

Do you exercise? (type duration, frequency)____

ACUPUNCTURE INFORMED CONSENT FOR EXAMINATION & TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the licensed acupuncturist or other licensed acupuncturists who now or in the future treat me while associated with or serving as back-up for the licensed acupuncturist working at the present clinic.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, tui-na (Chinese massage), infrared light, gua-sha, Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects including temporary pain and discomfort, possible temporary aggravation of prior existing symptoms, bruising and/or numbness near the needle sites that may last a few days. Dizziness or fainting may occur. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

Burns and/or scarring are potential risks of moxibustion, infrared light and cupping. Bruising is a common side effect of cupping and some types of tui-na (Chinese massage).

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that may be recommended are considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are gastrointestinal symptoms, headache, and rashes. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical and administrative staff to be able to anticipate and explain all possible risks and complications of treatment. I understand that results are not guaranteed and that judgment exercised by the clinical staff during the course of treatment will be based upon the facts then known is in my best interest.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent

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 understand that while this document describes the major risks of treatment, other side effects and risks may occur. 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 or Guardian Signature Date