Kathy Schoenberger, L.Ac., LLC
PATIENT INTAKE FORM

Personal Information

Date _____

Name _____

Phone: Home/Cell _____ Work _____

Email _____

Address _____

Birth date _____ Age_____

Occupation_____

Emergency Contact:

Name_____ Phone_____

Primary Care Physician_____

Referred by _____

Current Health Concerns

What is your main reason for today's visit?

_____

How long have you had this condition?

_____

What makes it feel better / what makes it worse?

_____

Are you being treated by other practitioners (PT, chiropractic) / for how long?

_____

What would you most like to achieve by receiving acupuncture treatments?

_____

Health History

Please indicate if any of the following pertain to you:

Pacemaker___ Blood-thinning Meds___ Pregnant___ Implants___

Medications and supplements you are currently taking

_____

_____

_____

Accidents, injuries or trauma you've experienced, including date and complications

_____

_____

Past hospitalizations and/or surgeries, including the year

_____

Please indicate if you have any of the following conditions

Allergies____ Asthma____ Sinus Issues____ Acne____ Eczema____

Arthritis ____ Knee Pain____ Low Back Pain____ Tinnitus/Ear Ringing____

Headaches____ Dizziness____ Eye Pain____ Peripheral Numbness/Tingling____

Stomach Pain/Indigestion____ Low Appetite____ Acid Reflux/Heartburn____

Bloating____ IBS____ Diarrhea____ Constipation____ Crohn's Disease____

Low Energy_____ Chronic Fatigue_____

Palpitations____ High Blood Pressure____ Chest Pain____

Mood Swings____ Anxiety____ Depression____ Insomnia____ Phobias____

Severe Menstrual Pain____ Heavy Periods____ Irregular Periods____ PMS____

Infertility ____ PID____ Endometriosis____ Fibroids____ Bladder Issues____

Hot Flashes____ Night Sweats____ Memory Issues____ Lack of Focus____

Diabetes____ Cancer____ Autoimmune Disease____(please specify below)

Please list any other health concerns

_____

_____

Kathy Schoenberger, L.Ac.

Acupuncture Informed Consent to treat

I understand that I am the decision maker for my health care. Informed consent involves my understanding and agreement regarding the care provided, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me by the acupuncturist named on this consent form. I understand that methods of treatment additional to acupuncture are available including, cupping, Gua Sha, electro-acupuncture, Tui-Na massage, Chinese herbal medicine, and nutritional counseling. I have been informed that acupuncture is a generally safe method of treatment, but as with all types of health care interventions there are some risks, including, but not limited to bruising, tingling, or dizziness. Extremely unusual risks of acupuncture include nerve damage and pneumothorax due to the minimal length and shallow insertion of needles. Infection is also an extremely unusual risk due to the use of sterile disposable needles, and a clean and safe environment.

I understand that I must fully inform my practitioner of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand that my records will be kept confidential and will not be released without my written consent. I understand that there are treatment options available for my condition other than acupuncture procedures. I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

By voluntarily signing below, I confirm that I have read 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 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.

Date: _____

_____ _____

Patient Signature Printed Name

_____

Practitioner's Signature