ACUPUNCTURE INTAKE FORM

MEDICAL HISTORY

This information is essential for the diagnosis procedure and helps to provide you with a better treatment. Please fill out as accurately as you can.

This information is **confidential**.

Name: Date:

Address:

Home phone: Cell:

Email address:

Age: Birth date: Height: Weight:

Occupation:

How did you hear about us?

Primary Care Provider:

Permission to contact your physician regarding your complaint? YES NO

Describe your principal complaint:

What types of treatments have you tried?

Medical diagnosis:

When did your symptom begin?

Childhood illnesses: Surgeries or Accidents?

Age:

Age:

Adolescent illnesses: Surgeries or Accidents?

Age:

Age:

Adulthood illnesses: Surgeries or Accidents?

Age:

Age:

Please note all major illnesses in your immediate family, like diabetes, heart disease, blood pressure, neurological disorders, psychological disorders, blood disorders, orthopedic disorders, etc and biomedical devices, such as artificial joints and pace makers.

Please note all medications, allergies to medications, herbs, vitamins, and minerals you take even if you take them only occasionally.

Please describe the levels of stress in you life. How does stress impact you? How do you deal with stress?

What types of acute illness do you get and how often have you experienced them during the last two years?

Are you presently being treated with other modalities? If so, which ones?

WOMEN BORN:

Date of last menstrual period:

How many days is your flow?

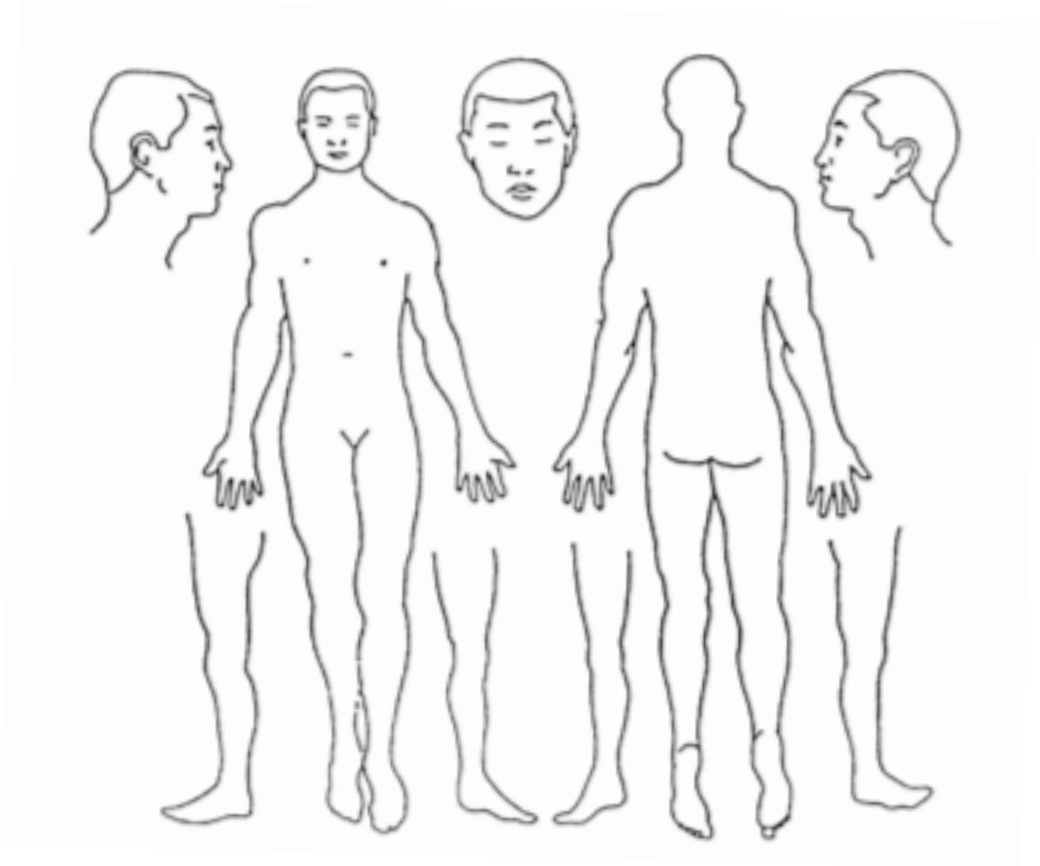
How many days is your monthly cycle?

Age you first began menses: menopause:

MEN BORN:

Have you ever had a prostate examination? If so, when?

ALL PATIENTS: please mark any areas of pain & presence of biomedical devices on the diagram below:



Thank you for your honesty. It will help to better understand your complaint, lead to a more accurate diagnosis, and guide us toward your improved health.

All patients are advised to consult a physician regarding the condition or conditions for which they are seeking acupuncture treatment. In addition, patients are responsible for seeking the advice and treatment of a physician should their symptoms change for the worse, or should any new condition arise.

CANCELLATION POLICY

I agree to pay the full price of a session if I do not comply with notifying Chad Johnson within 24 hours before my scheduled appointment time.

Signature of patient or patient representative Date:

ADVISORY TO CONSULT PHYSICIAN

I, (print name)_____have been advised by Chad Johnson, LMT, LAc to consult a physician regarding the conditions, for which I seek acupuncture treatment(s).

_____

Signature of patient or patient representative Date :

INFORMED CONSENT

The information attained on the intake form is true to the best of my knowledge.
I freely give my permission to receive acupuncture treatment which includes, but is not limited to the following methods; massage, acupuncture, moxibustion, cupping, gua sha, electric stimulation, and external herbal applications.
I have been informed that acupuncture is a safe form of treatment, but may have side effects, which include numbness, tingling, or bruising at the site of insertion. More unusual risks are spontaneous miscarriage, organ puncture, or nerve damage. Infection is also a risk, but this is highly unlikely since this office only uses disposable, sterilized needles in a clean, sanitary environment. Potential side effects of moxibustion are burning and scarring which will be minimized with the use of herbal burn cream.

I understand that Chinese Medicine, as well natural and alternative medicinal practices often fall outside of the approval by entities such as the FDA, the AMA, and the Dietetic Association to name a few. I understand that I am entering into treatment of my own volition whether there is FDA approval or not. I understand that I have the right to refuse any herbal medicine, vitamins, supplements, stone medicine, tinctures, elixirs, device, equipment or protocols that may be suggested as part of a treatment plan.

I understand I have the right to refuse any treatment or ask that it be modified in regards to modality or intensity. I agree to inform the practitioner of any experience of pain during the initial and subsequent sessions. I understand that I will be draped during treatment and that I may request additional draping if desired. During future sessions, I agree to update the practitioner on changes in my health status and medical history and understand that there shall be no liability on the practitioner's part if I should neglect to do so.

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Signature of patient or patient representative Date: