PATIENT INTAKE FORM

CONTACT INFORMATION:

Name: _____ Date of Birth: _____ Age:_____

Address: _____ Postal code:_____
Home phone: _____Cell: _____ Email:_____

Emergency contact name: _____
Number: _____

HEALTH HISTORY:

Check the applicable space if you have any of the following condition:

Cancer___ Diabetes___ Circulatory___ Liver disease___ Stroke___

Skin___ Seizure ___ Heart Disease___ Asthma___ Digestive___

Arthritis___ Insomnia___ High/low Blood Pressure___ Neurological___

Depression/Anxiety___ Cholesterol___ Bleeding disorder___

History of fainting___ Hepatitis___ HIV___ Circulatory impairment___

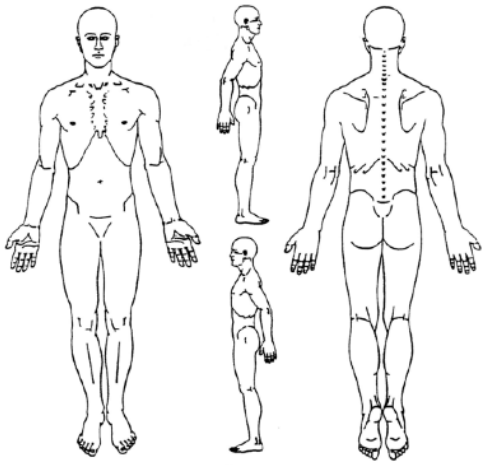
Infectious diseases (specify)_____ Fibromyalgia____ Thyroid___

Surgeries, Traumas_____

Other (specify)_____

Allergies:_____

Please indicate areas of body pain on diagram below



Current medications, including herbal:_____

_____

_____

CURRENT HEALTH CONCERN:

Please identify the health concerns that have brought you to the Clinic:

_____

_____

_____

How long have you had this condition?_____
What do you believe caused this condition?_____
Does anything make your condition feel better?_____Worse?_____
What other treatments are you having for this condition?_____

LIFESTYLE:

Smoking_____per day Occupational stress Y/N Home/family stress Y/N
Alcohol_____per day/wk/mo Shift work Y/N Regular exercise Y/N
Hobbies:_____
Job/career:_____
Diet / Do you feel like you eat healthy?_____

Who can we thank for referring you here? friend, website, newspaper... _____

CONSENT TO TREATMENT:

I hereby agree and consent to the performance of acupuncture and other modalities related to Chinese medicine. I understand that such modalities may include acupuncture, moxibustion, cupping, electro-acupuncture, tui-na (Chinese massage) and Chinese herbal medicine.

I am aware that in all acupuncture treatments only sterile, disposable needles are used according to the Clean Needle Technique protocol.

I am aware that acupuncture is a safe method of treatment, but may have some side effects, including bruising, minor swelling, numbness or tingling, dizziness or fainting. A sensation of light - headedness may occur after acupuncture treatment. I will immediately notify the acupuncturist if I experience any symptoms or problems.

I understand that I should not make significant movements while the needles are being inserted, manipulated, retained, or removed.

I am relying on the acupuncturist to exercise judgment during the course of my treatment. I understand that acupuncture and other Oriental Medicine procedures are not substitutes for treatment by my medical doctor. Also, at any given time throughout the treatment, I may request the practitioner to stop, modify or change the treatment plan.

By voluntarily signing below I certify that I have read this entire form, am aware of the risks and benefits of acupuncture and other procedures, and will have an opportunity to ask questions. I intend this consent form to cover the entire course of treatment to be performed for my present condition and for any future condition(s) for which I seek treatment.

Date: _____

Print Name of Patient _____

Signature of Patient_____

Parent or gaurdian *(if patient under 18 years of age)*_____
_____