# Confidential Patient Intake Form

## Personal Information

Today's Date:_____

Name: _____ Date of Birth:_____

Address:_____ Height:_____Weight:_____Sex: M / F

_____

_____ Occupation:_____

_____

Phone: _____ Care Card Number: _____

Email: _____ I consent to receive electronic communication via email.
( Initial _____ )

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**Physician(s) Information:**

Name: _____
Phone: _____

Name:_____
Phone:_____

**Emergency Contact:**

Name:_____
Relation:_____
Phone:_____

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## Lifestyle Choices

**Habits** (please check all that apply, and provide the frequency and amount of use):

Alcohol_____ Tobacco_____
Caffeine_____ Sugar_____
Recreational Drugs_____ Other_____

**Diet** (without going into great detail, please describe your daily diet, indicating which foods you consume most often):_____

_____

_____

**Exercise** (please indicate your frequency of exercise):

daily 3-4 times weekly 1-2 times weekly not at all

Please describe your routine and/or list your favorite activities:

_____

_____

## Medical Information

**Health Concerns** (please briefly describe the reason for today's visit):

_____

_____

**Health Conditions** (please check all that apply, past and present):

| | | |
|---|---|---|
| AIDS | German Measles | Multiple Sclerosis |
| Alcoholism | Goiter | Mumps |
| Allergies | Gout | Obsessive Compulsive |
| Anemia | Heart Disease | Osteoarthritis |
| Anorexia | Hepatitis A | Osteomalacia |
| Appendicitis | Hepatitis B | Osteoporosis |
| Arteriosclerosis | Hepatitis C | Parkinson's |
| Asthma | Hernia | Pneumonia |
| Bleeding Disorder | Herpes Simplex 1 | Polio |
| Bronchitis | Herpes Simplex 2 | Prostate Disorders |
| Bulimia | High Blood Pressure | Psoriasis |
| Cancer | High Cholesterol | Psychiatric Care |
| Candidiasis | Hyperglycemia | Rheumatic Fever |
| Cataracts | Hypoglycemia | Rheumatoid Arthritis |
| Chicken Pox | Jaundice | Seizures |
| Chronic Fatigue | Kidney Disorders | Stomach Ulcers |
| Chronic Pain | Liver Disorders | Stroke |
| Convulsions | Low Blood Pressure | Thyroid Disorders |
| Depression | Lupus | Tonsillitis |
| Diabetes | Measles | Tuberculosis |
| Eczema | Menstrual Disorders | Urinary Tract Infections |
| Emphysema | Migraines | Venereal Disease |
| Epilepsy | Miscarriage | Other_____ |
| Gallbladder problems | Mononucleosis | |

**Family History:**

| | | |
|---|---|---|
| Arthritis | Drug Dependencies | Obesity |
| Asthma | Heart Disease | Stroke |
| Cancer | High Blood Pressure | Other_____ |
| Depression | Kidney Disease | Other_____ |
| Diabetes | Liver Disease | |

**Allergies** (please list any allergies):

_____

_____

**Hospitalizations** (please note circumstances):

_____

_____

**Medications and Supplements** (please note medication and/or type and dosage)

_____

# Informed Consent to Treatment

I understand that acupuncture treatments are a safe and natural form of healing and recognize the potential risks and benefits as stated below. Forms of treatment may include acupuncture, cupping, moxabustion, electrical stimulation, and dietary / lifestyle recommendations.

Potential benefits: Relief of presenting symptoms, improved health and wellbeing, reduced stress and an overall balance of bodily energies which may lead to prevention or elimination of the main complaint(s).

Potential risks: Although uncommon, there is a potential for acupuncture treatment to cause temporary bruising, swelling, bleeding, numbness, tingling and soreness at the site of the needle and such symptoms may last a few days. Unusual risks associated with acupuncture include dizziness, fainting, nerve damage, or possibly the aggravation of symptoms existing prior to treatment. Pneumothorax is a very rare and unlikely side-effect of acupuncture. Infection is a slight possibility even though at this clinic, only one-time-use sterile, disposable needles are used, and a clean and safe environment is universally maintained. Moxabustion and cupping treatments carry the potential risks of temporary bruising or blistering. I understand that I will not make any large movements during the acupuncture treatment, and that some articles of clothing may need to be removed in order to gain access to areas of the body under treatment.

Pregnancy: Acupuncture can be very beneficial in the treatment of symptoms during pregnancy, assisting in the birthing process, or postpartum. I will notify my acupuncturist should I become pregnant, or if I am in the process of trying to become pregnant so that my practitioner can avoid points that could induce premature labor or miscarriage.

Cancellation Policy: I understand that scheduling an appointment involves the reservation of time at the clinic specifically for me, and I agree to give at least 24 hours of notice to cancel or reschedule an appointment. I will be charged $35 for treatments missed without sufficient notice.

Privacy: I understand that records will be kept by the clinic of services provided to me. These records will be kept confidential and will not be released to anyone unless specifically directed by me in writing. I may look at my patient file at any time, and can obtain a copy by paying the appropriate photocopying fee.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. 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.

| Printed Patient Name | Patient Signature | Date |
| --- | --- | --- |