ACUPUNCTURE PATIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a patient of .
Information collected about new patients is confidential and will be treated accordingly.

ICD-10 Code(s): _____ Date of first treatment: _____

PATIENT GENERAL INFORMATION

Name: _____ **Age**: _____ **Birthdate**: _____

Home Phone: _____ **Cell Phone**: _____

Email: _____ **Address**: _____

Occupation: _____ **Marital Status**: _____

Emergency Contact Name: _____ -Phone: _____

Primary Care Physician: _____ -Phone: _____

Are you or your spouse a veteran? ☐ Yes ☐ No

Who referred you to the clinic? _____

HEALTH CONCERNS

What are your present health concerns?

-How does this problem affect your daily activities?

-When did you first notice symptoms? _____

-What prior diagnoses have you received and what treatments or therapies have you tried?

Any hospitalizations, surgeries, or accidents?

Any allergies? _____

Please describe any painful or distressed areas on your body:

How would you describe your exercise level?

☐ Sedentary ☐ Mild exercise ☐ Occasional workouts ☐ Regular workouts

Please list any drugs, herbs, or supplements you currently take:

ACKNOWLEDGMENT

Acupuncture is a healing art that stimulates specific points on the body to treat diseases or relieve pain. Stimulation may be produced by needles, heat, digital pressure and electrical currents, etc., but most frequently in the form of needling. In rare incidents, patient may experience certain side effects or reactions including fainting, bleedings, pneumothorax, puncturing of viscera, broken needles and other hazards associated with the treatment procedures. Although acupuncture has been used in Eastern and European countries as an authentic therapeutic modality, it is still considered experimental in the United States, implying there may be unknown risk factors involved.

I have read the above regarding the potential hazards of acupuncture treatment, and I understand that no guarantee of results has been made. I consent to such treatment and release the _____ and its practitioners from any and all claims of damages for any injury which may result from the treatment.

Patient signature: _____ Date: _____

Print name: _____

Parent/Guardian signature: _____ Date: _____

Print name: _____