ACCESSIBLE ACUPUNCTURE
ACUPUNCTURE FOR THE PEOPLE

Registration Form / Health History Questionnaire

Name _____ **Preferred Name** _____ **Date of Birth** ___/____/____

Address _____
Street Apt# City State Zip Code

Phone _____ **Email** _____
Home Cell

Female / Male / Trans (FtM / MtF) / **Other:** _____ **Preferred Pronoun:** He / She / Other: _____
(Circle One) (Circle One)

How did you learn about us? _____ **First time getting acupuncture?** _____

Occupation _____ **Company** _____

Emergency Contact _____ **Relationship** _____ **Phone** _____

Signature _____ **Date** _____/_____/_____

* * * * * **Please list your PRIMARY reason(s) for coming in for treatment** * * * * *

Concern #1: _____

Level of Intensity/Discomfort/Pain from 1 (minor) to 10 (worst)**:** _____

What makes it better?_____ **What makes it worse?** _____

Concern #2: _____

Level of Intensity/Discomfort/Pain from 1 (minor) to 10 (worst)**:** _____

What makes it better?_____ **What makes it worse?** _____

*Please **FILL IN THE BLANKS** and **CIRCLE** the underlined options **only if they apply to you***

I am / am not interested in possibly addressing these issues, or others I may be experiencing, with Chinese Herbal Medicine

I have high / moderate / low **stress.** Stress impacts me physically in the following way:_____

I often / rarely have **headaches**. The headaches are located: Top / Back / Sides / Temples / Sinuses / Forehead / Eyes

Anything else you think we should know? _____

For Women:

I experience no / minor / severe PMS. I experience cramping / mood swings / irregular cycle / clots / abnormal bleeding.

PREGNANCY: I am / am not / am trying to get pregnant. I have been pregnant for _____weeks.

Please Read & Sign The Informed Consent Form On The Other Side

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Acupuncture Informed Consent To Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture in the State of Florida on me (or on the patient named below for whom I am legally responsible) by the acupuncturist and/or other licensed acupuncturists who now, or in the future, treat me while employed by, or working in association with, Accessible Acupuncture.

I understand that while acupuncture is a generally safe method of treatment it may have some risks and side effects including temporary bruising, numbness, tingling and soreness at the needle site that may last a few days and dizziness or fainting. Unusual risks of acupuncture include the aggravation of symptoms existing prior to treatment, spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another rare, yet possible, risk although the clinic uses sterile single-use disposable needles and maintains a clean and safe environment.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that may be recommended are traditionally considered safe in the practice Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may need to be prepared and the teas consumed according to the instructions provided orally and/or in writing. The herbs may have an unpleasant smell or taste. Some possible side effects of taking herbs are nausea, gas and stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with consumption of the herbs.

Acupuncture can be very beneficial in assisting women to get pregnant during pregnancy, assisting in the birthing process and postpartum. I also understand that some herbs may be inappropriate during pregnancy.

Before every single treatment, **I will notify the clinical staff member who is caring for me should I become pregnant or if I am in the process of trying to get pregnant** so that my practitioner can take appropriate precautions**.** Although research studies conclude that "acupuncture appears to be safe for patients on blood thinners" and "acupuncture has a high degree of safety in patients receiving anti-coagulation therapy", **I will also alert my acupuncturist if I have a bleeding disorder or I am taking any anti-coagulant or anti-platelet medication**.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of the treatment which the clinical staff thinks at the time, based on the facts then known, is in my best interest. I understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment, or series of treatments.

I understand that the staff may review my medical records and lab reports, but that all my records will be kept confidential and will not be released without my written consent or as required by law. I understand that the acupuncturist is not providing Western (allopathic) medical care, and that I should look to my primary care practitioner for those services and routine check ups. I understand that the acupuncturist is not equipped to give advice regarding the pharmaceutical medications I may be taking and any adjustments I make with regard to my intake of those medications should be done following a consultation with my prescribing physician(s).

I have read or have had read to me the above consent. I have had the opportunity to ask questions about its content and by signing below I agree to receive treatment. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I may seek treatment.

To be completed by the Patient or Patient Representative:

PATIENT NAME (Printed): _____ DATE: _____

SIGNATURE (Patient Or Patient Representative): _____

Name of Patient Representative & Relationship to Patient (if applicable): _____