Don Thompson DAC LAC

Acupuncture for Chronic Illness

WELCOME!

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: _____Work: _____ Cell: _____

Email: _____ May We Email You? YES NO

May we leave messages on phone numbers listed above? YES NO Which? _____

Age: _____ Date of Birth: _____ Marital Status: _____

Name of Legal Guardian: _____

Phone: _____ Relationship: _____

Emergency Contact: _____

Phone: _____ Relationship: _____

How did you hear about our clinic? _____

If individual, may we thank them for the referral? YES NO

Name: _____

Physician Name: _____ Phone: _____

I understand that although rare, there are some potential side effects of acupuncture which include the following: fainting, bruising, light headed, and fatigue; extremely rare occurrences of nerve damage and pneumothorax ("collapsed lung") have been reported. Like all forms of health care, there are no guaranteed results from acupuncture treatment. I agree to tell my acupuncturist immediately of any changes in my health, and fully understand that is in my best interest to consult with a medical doctor for an evaluation of my symptoms.

I understand that payment for services is due at the time services are rendered unless other arrangements have been made. I agree to give 24 hours notice of appointment change or cancellation, or I agree to pay the full fee for missed appointments. I understand that I will be given a "superbill" at the conclusion of each visit, and that is my responsibility to submit it to my insurance company for reimbursement if I have an insurance policy which covers acupuncture services.

_____ _____

(Signature) (Date)

Health History Check-List

Patient _____ Date _____

Please check if you have had the following health concerns / complaints.

General

Hepatitis ____
HIV ____
Cancer ____
Diabetes ____
Bleeding Disorder ____
Medication ____
Vitamins ____
Blood Thinning ____
Medication ____
Smoking ____
Alcohol Use ____
Preganancy ____
Fatigue ____
Pacemaker ____

Skin & Hair

Rashes ____
Itching ____
Dandruff ____
Eczema ____
Loss of Hair ____
Hives ____
Pimples ____
Moles ____
Other ____

Medication

_____
_____
_____
_____
_____
_____
_____
_____
_____

Head, Ears, Nose, Throat

Headaches ____
Dizziness ____
Concussion ____
Migraine ____
Eye Pain ____
Blurry Vision ____
Poor Night Vision ____
Cataract ____
Ringing In Ear ____
Earaches ____
Poor Hearing ____
Dental Problems ____
Teeth Grinding ____
Facial Pain ____
Jaw Clicks ____
Other ____

Cardiovascular

High Blood Pressure ____
Low Blood Pressure ____
Palpitations ____
Cold Hands / Feet ____
Chest Pain ____
Phlebitis ____
Other ____

Respiratory

Cough ____
Coughing Blood ____
Asthma ____
Bronchitis ____
Pneumonia ____
Pain with Breathing ____
Sputum ____
Other ____

Gastrointestinal

Nausea ____
Vomiting ____
Belching ____
Diarrhea ____
Constipation ____
Excessive Gas ____
Blood In Stool ____
Mucus In Stool ____
Indigestion ____
Bad Breath ____
Stomach Pain ____
Hemorrhoids ____
Other ____

Urogenital

Pain on Urination ____
Urgency to Urinate ____
Blood in Urine ____
Unable to hold Urine ____
Decrease in Flow ____
Kidney Stones ____
Sores on Genitals ____
Impotency ____
Decreased Libido ____
Other ____

Mental / Emotional

Anxiety ____
Depression ____
Insomnia ____
Irritability ____
Tearful ____
Other ____

Other

_____
_____

Patient _____ Date _____

Why have you come for acupuncture?

_____

_____

How long have you had this / these problem(s)?

_____

_____

Is / are the symptom(s) getting worse, better, or staying the same?

_____

_____

What other types of treatment / evaluation have you had for this / these problem(s) (medical evaluation, MRI/CT/XRay, chiropractic, massage, physical therapy, etc)? _____

_____

_____

What are your expectations of acupuncture treatment?

_____

_____

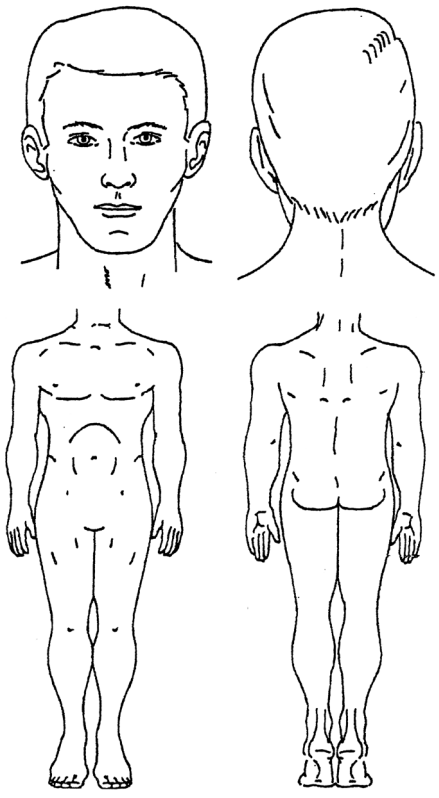
Please list any concerns you would like to discuss with the acupuncturist: _____

_____

_____

_____

Show me where it hurts! Please circle the area(s) you are experiencing pain or discomfort. Please indicate on a scale of 1-10, where 1 is minimal pain and 10 is extreme pain, your level of pain today.



Acupuncture Clinic

I understand that it is in my best interest to see a physician (Medical Doctor or Doctor of Osteopathy) for any health concerns or symptom I may be experiencing. I have either seen a physician or agree to see a physician for an evaluation of any health concern or symptom for which I am seeking acupuncture care. I agree to inform my acupuncturist about any medical treatments I am receiving, any changes in my symptoms, or any new symptoms I may experience while under acupuncture care.

I understand that there is no guarantee that acupuncture will work for my particular condition or symptoms.

Side effects of acupuncture are rare, but may include redness, swelling, or bruising where needles are placed. Other side effects may include dizziness, fainting, or feeling light headed. Extremely rare consequences of acupuncture include pnumothorax, and nerve damage, though this rarely occurs with a skilled acupuncturist.

I understand that payment for services are due at the time services are rendered unless previous arrangements have been made. I also agree to give 24 hours notice of cancellation or change of my appointment time, and understand that I may be charged for appointments missed or changed without 24 hours notice.

_____

(Patient Signature) (Date)

_____

(Acupuncturist Signature) (Date)