New Patient Acupuncture Intake Form

298 Old Route 30
Greensburg, PA 15601

Patient Information

Name: _____
Date: _____
Address: _____
City/State/Zip: _____
Birthdate: _____ Age: _____
Gender/Preferred Pronoun: _____
Occupation: _____
Is this your first time getting acupuncture? Yes / No
How did you hear about us? _____

Contact Information

Phone Number: _____
Would you like Text Reminders?: Yes / No
Email: _____

Emergency Contact

Name: _____
Phone Number: _____
Relationship: _____

Please indicate if any of the following pertain to you:

▫ Hepatitis ▫ HIV/AIDS ▫ High Blood Pressure ▫ Pregnancy ▫ Seizures ▫ Fainting Disorder
▫ Bleeding Disorder ▫ Pacemaker ▫ Blood-Thinning Medication

Health History

1. What is your primary reason for seeking acupuncture treatment?

_____
When did this start?_____
What was the cause of the problem?_____
What makes it better? _____
What makes it worse? _____
What treatment have you tried? Were any of them helpful? _____
_____
What medical diagnosis have you been given, if any?_____
Does it interfere with your daily life and/or work? _____
Please rate the intensity of your issue on a scale of 0-10, with 0 as non-existent and 10 as the worst you have experienced.

_____
0 1 2 3 4 5 6 7 8 9 10

2. Is there another issue you want to work on with acupuncture?

_____
When did this start? _____
What was the cause of the problem?_____
What makes it better? _____
What makes it worse? _____
What treatment have you tried? Were any of them helpful? _____
_____
What medical diagnosis have you been given, if any?_____
Does it interfere with your daily life and/or work? _____
Please rate the intensity of your issue on a scale of 0-10, with 0 as non-existent and 10 as the worst you have experienced.

_____
0 1 2 3 4 5 6 7 8 9 10

3. Are there any other health concerns you'd like us to know about?

_____

4. Please list (with approx. dates) any serious illnesses, injuries, surgeries or hospitalizations:

_____
_____

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5. Please list any prescription or over-the-counter medications, vitamins, and supplements you are presently taking and the reason for taking them:

_____

_____

_____

_____

6. Please list any allergies (drugs, chemicals, food):

_____

_____

Other Health Information

How is your sleep? _____

Do you feel like you have enough energy to get through your day? _____

Have you ever been treated for emotional problems? _____

Do you have any trouble with digestion? _____

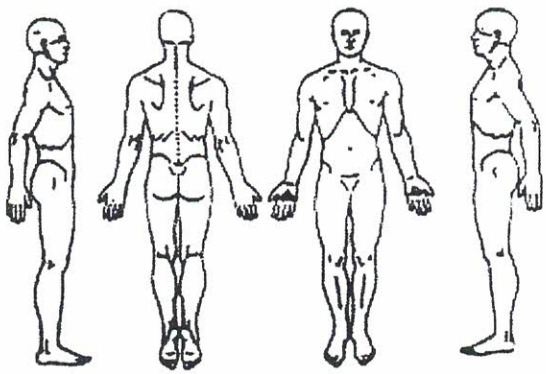
How many cigarettes do you smoke a day? _____ How much alcohol do you drink per week? _____

How much coffee/tea or cola do you drink per day? _____ Any special diet? _____

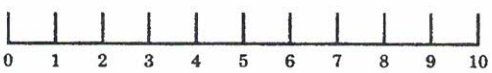
Do you have a regular exercise program? If so, describe: _____

For those who have a period, when was your last one?_____ Do you have regular or irregular cycles and do you suffer from PMS?_____

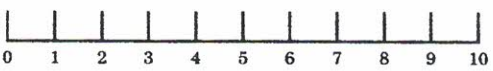
AREA(S) OF PAIN OR DISCOMFORT Mark the areas on the figures below by circling the particular area of discomfort including radiating pain



On a scale of zero to ten, rate your **discomfort:** (0=no discomfort 10=severe-unable to preform daily tasks)



On a scale of zero to ten, rate your **current stress level**: (0=none 10=severe-unable to preform daily tasks)



Acupuncture Informed Consent to Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Bartlett Acupuncture. (Licensed Acupuncture) and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named above, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that the acupuncturist cannot treat me for a given condition beyond 60 calendar days from the date of first treatment, unless I obtain an examination and diagnosis from a physician, dentist, or podiatrist for that condition. I understand methods of treatment include, but are not limited to, acupuncture, moxibustion, cupping, gua sha, electric stimulation, Tui-Na (Chinese massage), and nutritional counseling.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain and to treat certain diseases of dysfunction of the body. I have been informed that acupuncture is a generally safe method of treatment, but occasionally there may be some side effects, including bruising, dizziness, fainting, or numbness or tingling near the needle sites that may last a few days. Bruising is a common side effect of cupping. There have been rare and unusual risks of acupuncture including nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this office uses sterile disposable needles and maintains a clean and safe environment. Burns and/ or scarring are a potential risk of moxibustion, cupping, and the use of the heat lamp and can be refused at any time. I understand while this document describes the major risks of treatment, other side effects and risks may occur.

I do not expect the staff to explain and anticipate all possible risks and complications of treatments. I do not expect the clinical staff 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 judgement during the course of treatment which the clinical staff thinks at time, based upon the facts then known is in my best interest. I understand that results are not guaranteed and that I can stop treatments at any time. I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent. I will notify the practitioner immediately of unpleasant or unanticipated side effects associated with treatment.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition for any future conditions for which I seek treatment.

_____ _____

Patient Signature Date

(Include relationship if signing for patient)

Bartlett Acupuncture

APPOINTMENT CANCELLATION POLCY

Below outlines the Appointment Cancellation Policy for Bartlett Acupuncture.

We respectfully request 24 hours of notice for any appointments that you are unable to attend.

1. We reserve the right to charge a **$75.00 No-Show** fee for patients who do not provide adequate notice.

2. Should you miss two (2) consecutive appointments without notice, all future appointments will be automatically cancelled and reassigned to other patients. Should you wish to reschedule your cancelled appointments, you will need to contact the office to reschedule your future appointments.

I acknowledge that I have read and understand the Informed Consent and Cancellation Policy at Bartlett Acupuncture.

_____ _____

Signature **Date**

_____

Printed Name