

Arrowhead Acupuncture and Holistic Health - Confidential New Patient Intake Form

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Name _____ Gender _____ D.O.B _____ Age _____

MailingAddress _____ Cell # _____ ok to text _____

_____ Email _____

_____ Emergency Contact _____

Referred by _____ Phone _____

Height _____ Current Weight _____ Weight you feel the best at _____

Marital Status _____ Number of Children _____ Occupation _____ Hrs/week _____

Have you had Acupuncture before _____ Condition Treated _____ Effectively _____

Main reason you are seeking treatment today _____

Onset _____ Getting worse _____ Effect work _____ Sleep _____ Other _____

Other therapies you are currently using for this condition including Practitioners name, phone# and how often

Primary MD name and phone _____

Exercise/Activities _____ How often _____

Is your condition worse/better after activity _____ after rest _____ Tend to feel hot or cold _____

Prescription Medications and Supplements with dosage and date you began taking them _____

Current Medical Conditions _____

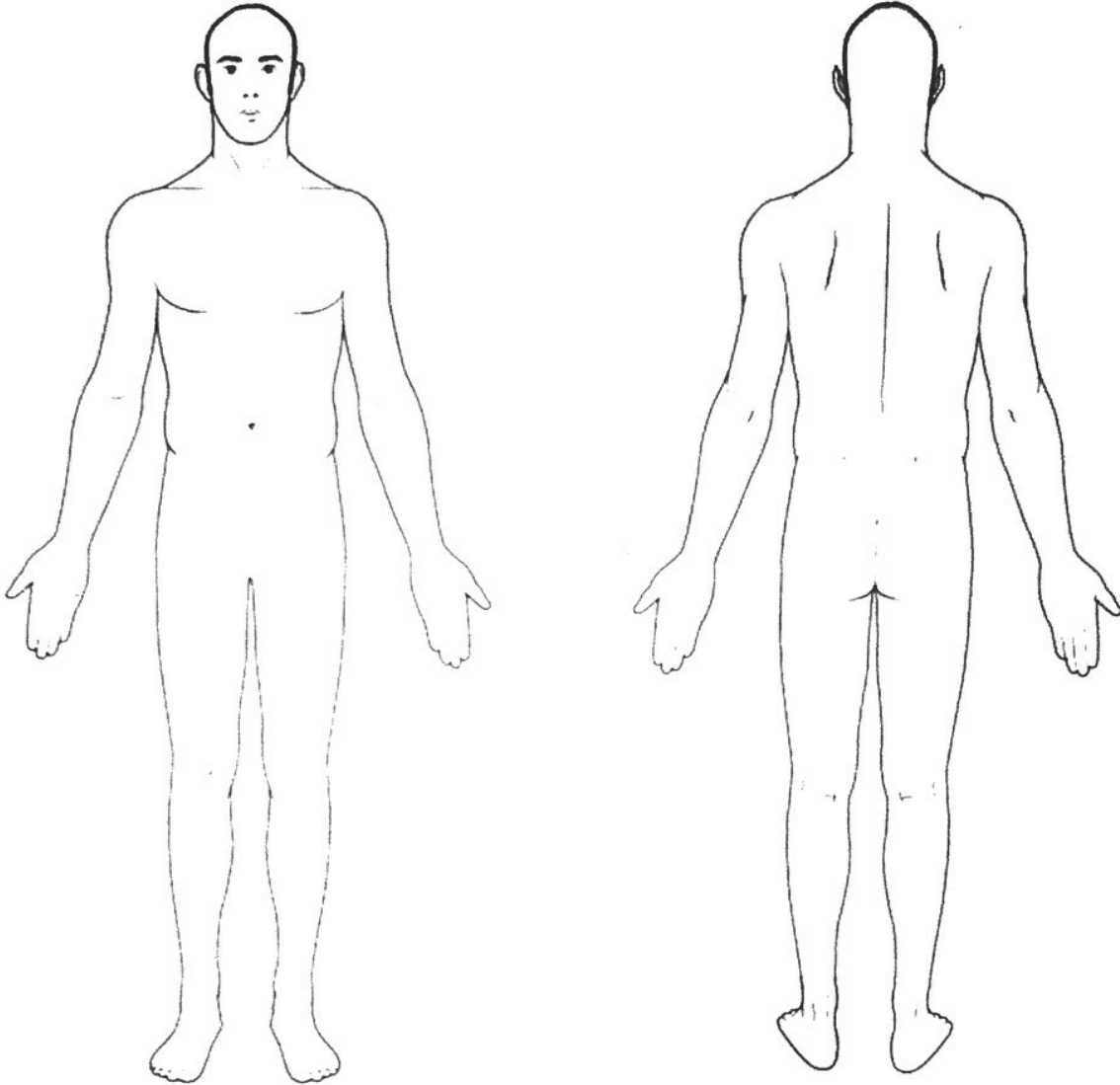
Any contagious diseases _____ HIV _____ Hep A,B or C _____ Other _____ Date contracted _____

Past Medical Conditions by date from most recent _____

Familial Medical Conditions/causes of death _____

Allergies to corn/potato/other _____

**Please illustrate on the diagram any areas you have
pain (xxx) numbness(///) weakness(+) stiffness (000)**



How would you describe the pain i.e (sharp/dull etc). _____

Where would you put this pain on a 1-10 scale now _____ at its worst _____ average _____

Are you using Ice/heat, how often _____

Pain Killers/ how much / how often _____

External Applications _____

Past Surgeries by date from most recent _____

Proposed Surgeries and dates _____

Other _____

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 the acupuncturist(s) who now or in the future treat me.

I understand that methods of treatment may include, but are not limited to, acupuncture, Chinese herbal medicine, and nutritional counseling. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

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 judgment during the course of treatment, which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed. 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.

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 and for any future condition(s) for which I seek treatment.

I hereby give consent for Lucas Hausler to discuss my case with my other Doctors listed above: Initial _____

I understand there is a \$50 charge for any cancelations within 24 hrs of scheduled appointments: Initial _____

PATIENT PRINTED NAME _____

PATIENT SIGNATURE: _____ Date _____

PARENT OR GUARDIAN PRINTED NAME _____

SIGNATURE _____ Date _____