

acupuncture  together

Name _____ Date _____

Address _____ City/State/Zip _____

Cell Phone _____ Email _____

Date of Birth _____ Age _____ Have you had acupuncture before? _____

Occupation _____

Emergency contact name/phone _____

How did you hear about us? _____

What are you seeking treatment for?

Please list any hospitalizations, injuries, surgeries or other medical problems which have required a doctor's care in the last 5 years:

List prescriptions, over-the-counter medications, and supplements you are taking:

Are you allergic to anything? _____

Please mark all that apply:

- | | |
|--|--|
| <input type="checkbox"/> epilepsy/seizures | <input type="checkbox"/> pacemaker |
| <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> fainting |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> taking blood thinners |
| <input type="checkbox"/> bleeding disorder or hemorrhage | <input type="checkbox"/> mental illness |

Is there anything else you would like us to know about you? _____

Informed Consent for Acupuncture Treatment

I understand that:

- If I need to be woken up at a certain time, I will let the acupuncturist know.
- I might be too relaxed to drive immediately after treatment.
- If other people's snoring bothers me, I need to use earplugs or headphones.
- Community acupuncture involves actual community with a wide variety of people, and may require some flexibility, patience, and understanding.

I, the undersigned, hereby request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of Oriental Medicine. I am hereby informed that the treatment methods are all generally safe but that there may be some side effects or risks.

Potential Side Effects:

At the site of needle insertion there may be **soreness, numbness, tingling, bruising, swelling, or temporary nerve damage**. A person might also experience rare side effects such as weakness, fainting, burns, spontaneous miscarriage, organ puncture, and infection - although Acupuncture Together uses only sterile, disposable needles and maintains a clean and safe environment. Acupuncture can cause aggravation of symptoms existing prior to acupuncture treatment and appearance of new symptoms.

The herbal and nutritional supplements recommended to me by my practitioner are generally safe in the traditionally recommended doses. Possible side effects of herbs include nausea, gas, stomach ache, diarrhea, and headache. Unusual side effects of herbs include vomiting, rashes, hives, and tingling of the tongue. I understand I must stop taking any herbs and notify my acupuncturist if I experience any discomfort or adverse reaction.

I understand that I have the right to refuse any part of the treatment. I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose, although I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known. 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 with Acupuncture Together.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant as certain acupuncture points and herbs are contraindicated during pregnancy.

Patient Signature

Date

Cancellation Policy

If you have an appointment scheduled with us, we are saving a chair just for you.

Please note that there is a \$20.00 fee for appointments that are cancelled with less than 12 hours notice, and also for missed or no-show appointments. There are exceptions for emergencies.

With respect for our intention to offer high quality acupuncture at affordable prices, we ask for 12 hours of advance notice if you must cancel or reschedule an appointment. This gives us time to fill the vacant slot in our schedule, and helps us keep rates affordable. You may cancel or reschedule an appointment by phone or by using our online appointment scheduler. You may also leave us a voicemail outside of regular business hours.

Thank you for your understanding,

Acupuncture Together Staff

I affirm that I have read the cancellation policy and that I am aware of the \$20.00 fee for cancellations less than 12 hours before the appointment and also for missed/no-show appointments.

Patient Signature

Date

Form to be completed by Patient, Notifying the Acupuncturist of Whether He/She Has Been Evaluated by a Physician, and Other Information.

(Pursuant to the requirements of 22 TAC §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

I (patient's name) _____, am notifying the acupuncturists at Acupuncture Together of the following:

I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

Yes No

_____ (initials of patient) Date: _____

I have received a referral from my chiropractor within the last 30 days for acupuncture.

Yes No

After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

Patient Signature

Date