ACUPUNCTURE TOGETHER CONSENT TO TREAT:

Acupuncture is the stimulation of certain points near the surface of the body by insertion of needles to prevent or modify the perception of pain, normalize physiological functions and treat certain diseases or dysfunctions of the body. While most people find their treatments relaxing and/or energizing, there may be minor side effects, such as slight pain or discomfort at the site of needle insertion, bruises, weakness, fainting, allergic reaction to the metal needles, infection (rarely) or aggravation of symptoms existing prior to treatment.

Herbal medicine means using plant, mineral and animal (rarely) materials to address issues of the respiratory, nervous, endocrine, reproductive and digestive systems, and side effects may include symptoms in any of these areas.

Please let us know if you are or become pregnant before or during your course of treatment. Acupuncture and herbs are safe during pregnancy as long as your acupuncturist knows and can avoid contraindicated points and herbs. No absolute guarantee can be made about the efficacy of any treatment.

I agree to the above policy: Print Name: _____

Signature: _____ Date: _____

PAYMENT AND CANCELLATION POLICY:

Payment is due at the time of your treatment. In respect and consideration of others who also need appointments, **WE REQUIRE 3 HOURS NOTICE FOR ANY APPOINTMENT CANCELLATION OR RESCHEDULING TO A LATER TIME OR LATER DATE.**
Please cancel/reschedule your appointment online with 3 hours notice or more, or call the clinic as soon as possible if you need to cancel and/or reschedule to a later time/date.

ALL APPOINTMENTS THAT ARE CANCELLED WITH LESS THAN 3 HOURS NOTICE OR RESCHEDULED TO A LATER TIME OR DATE WITH LESS THAN 3 HOURS NOTICE, AND MISSED APPOINTMENTS WILL REQUIRE PAYMENT OF $25 BEFORE YOUR NEXT VISIT.

Thank you for your understanding!

I agree to the above policy: Print Name: _____

Signature: _____ Date: _____

SICK PATIENT POLICY:

IF YOU ARE FEELING SICK OR EXPERIENCING ANY COVID-19 SYMPTOMS (FEVER, COUGH, SORE THROAT, CHILLS WITH SHAKING, ETC.), PLEASE CANCEL YOUR APPOINTMENT ASAP (WITH 3 HOURS NOTICE IF POSSIBLE). We will not treat anyone who is sick at our facility. If you show up sick, we will need to turn you away without a treatment.

I agree to the above policy: Print Name: _____

Signature: _____ Date: _____

(please see other side)

ACUPUNCTURE TOGETHER HEALTH HISTORY FORM

Name: _____ Today's Date: _____/_____/_____
(FIRST) (LAST)
Date of Birth:_____/_____/_____ Age:_____ Gender:_____ Pronoun: _____

Address: _____ City:_____ State:_____

Phone: _____ Email:_____

Occupation:_____ Have you ever been treated by acupuncture? Y / N

Emergency Contact Name & Phone: _____

How did you find Acupuncture Together? _____

Please complete this questionnaire to the best of your ability. We will discuss your health concerns and review your form during your intake.

MAIN CONCERNS: please write in your top 3 health concerns in order of importance to you. Mark on the scale ranking the severity of the condition from 1-10, with 1 being barely noticeable and 10 being worst ever, and circle the items that make it better or worse. You may also fill in any other unlisted factors that make it better or worse.

1. _____

RANK SEVERITY: 1----------5----------10
When did this start? _____/_____ (give month/year to best of ability)
Is it better with (circle): heat cold damp weather exercise rest
Better with other:_____
Is it worse with (circle): heat cold damp weather exercise rest
Worse with other:_____

2. _____

RANK SEVERITY: 1----------5----------10
When did this start? _____/_____ (give month/year to best of ability)
Is it better with (circle): heat cold damp weather exercise rest
Better with other:_____
Is it worse with (circle): heat cold damp weather exercise rest
Worse with other:_____

3. _____

RANK SEVERITY: 1----------5----------10
When did this start? _____/_____ (give month/year to best of ability)
Is it better with (circle): heat cold damp weather exercise rest
Better with other:_____
Is it worse with (circle): heat cold damp weather exercise rest
Worse with other:_____

HISTORY OF INJURIES/SURGERIES (please note what happened, body area and date or age):
_____
_____

Please list any medications (prescribed and OTC), vitamins or supplements you are currently taking:
MED:_____ PURPOSE:_____
MED:_____ PURPOSE:_____
MED:_____ PURPOSE:_____
MED:_____ PURPOSE:_____

HABITS:	amount/week	if quit, when?		amount/week	if quit, when?
Coffee/Tea:	_____	_____	Alcohol:	_____	_____
Tobacco:	_____	_____	Drugs:	_____	_____

EXERCISE (type, frequency and amount):_____

CURRENT HEALTH (CIRCLE ALL THAT YOU HAVE EXPERIENCED IN THE LAST MONTH):

Body Temperature: Night sweats Hot flashes Hot face Cold hands/Feet
Do you tend to feel: Warmer than other people? Colder than other people?

Head: Headaches Migraines Eye pain/strain Eye floaters Dry eyes Itchy eyes
Ear ringing/Tinnitus Sinus problems Mouth sores TMJ/jaw problems
Seizures/Epilepsy Dizziness/lightheadedness Poor memory Cloudy/foggy-headed

Chest: Palpitations Shortness of breath Asthma Heart disease Low / High Blood Pressure

Thirst: Do you tend to be thirsty? Y / N Prefer cold, neutral or hot drinks?:_____

Skin: Dryness Itching Oily Acne Eczema Psoriasis Roseacea Rashes
Dandruff Hair loss Dry brittle nails Other:_____

Digestion: Poor appetite Excessive hunger Gas Bloating Heartburn Acid reflux
Abdominal pain Belching Nausea Vomiting Bad breath
How often do you have a bowel movement? _____ time(s)/ every _____ day(s)
Hard stool Hard to pass Incomplete stool Loose (not formed) stool Watery stool

Urination: Dark / Light / Clear Scant / Copious Urgent Frequent #times per night:_____

Energy/Immunity: Fatigue Body/limbs feel heavy Tired after eating
Reduced immunity (such as due to HIV, auto-immune disease or chemotherapy)? _____

Sleep: _____ hours/night Hard to fall asleep Hard to stay asleep Restless Tired in A.M.

Emotions: Irritability Depression Anxiety Mood swings Other_____

Female Reproductive: Age of first period:_____ Date of last period:____/____/____
Length of period:_____ Length of full cycle:_____ Are cycles regular? Y / N
Do you experience: Spotting Clots Heavy flow Light/Scanty flow
Cramps during PMS cramps PMS breast tenderness PMS emotional changes
PMS bloating PMS insomnia PMS other_____
Yeast infections Vaginal dryness Low libido
Are you pregnant? Y / N Total number of pregnancies:_____ Live births:_____
Menopause: Age of last menses:_____ Hot flashes _____x/day Night sweats _____x/week

Male Reproductive: Erectile dysfunction Prostate problems Testicular pain/swelling Low libido

Please list any other concerns you would like to let us know about: _____
_____
_____

(please see other side)