ACUPUNCTURE APPOINTMENTS

New Patient Visits:

* If you have not already filled out a New Patient Form please arrive 15 minutes earlier than your scheduled time in order to fill out the necessary paperwork.
* Please note that appointments are often scheduled outside of office hours. If you arrive to the office and find the door locked, please wait patiently while the previous patient visit is concluded.
* Please come prepared with a listing of all current medications and if possible bring the original containers.
* If you have any recent blood-work, x-ray or any other medical documents please bring these to your appointment. If you do not have any of these, we may request your permission to obtain these records from your doctor if it is necessary.
* Your initial appointment will be approximately 1 hr in length and will include the initial intake discussion and acupuncture treatment.
* Our office does not bill directly to insurance companies other than GreenShield. Receipts are issued at the conclusion of each visit for you to forward this documentation to your insurance provider. Our office strongly encourages you to contact your insurance company prior to your scheduled visit to determine your coverage for Acupuncture services.
* The cost of your first visit is **$110**
* Payment for services is rendered at the conclusion of each visit. Payment by cash, debit or credit is accepted. Direct billing is available for **GreenShield**.

# Follow-up Appointments:

* Best results with acupuncture are typically achieved with a series of acupuncture visits. For this reason, it is often recommended to schedule one acupuncture treatment weekly for the first 4 weeks. From there, a treatment schedule will be determined based on each individual.
* Each follow-up visit is approximately 30 minutes in length.
* The cost of each follow-up visit is **$60.**

**Missed Appointment Fee**

* A fee of $30 will be charged for any missed appointment or cancellation without 24hrs notice. Extenuating circumstances will always be taken into consideration.

**Scent Free Policy**

* Please refrain from wearing any fragranced products (perfume, cologne, lotion, deodorants, hair products, etc.) on the day of your appointment.

ACUPUNTURE INTAKE FORM

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work/Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can we leave messages relating to your visits (eg: reminder calls)? Y N

Emergency contact: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about the clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other health care providers you are seeing (ie. medical doctor, chiropractor, etc):

 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_

Your reasons for seeking acupuncture/treatment goals:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had acupuncture before: Y N

 If yes, please explain (what it was for, how was the experience)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do needles bother you: Y N

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:**

Do you see a medical doctor regularly: Y N

Do you get regular blood work: Y N

Do you currently have or have you ever had any of the following: (please circle)

AIDS

Allergies

Anemia

Anxiety

Arthritis

Asthma

Bipolar disorder

Cancer

Chronic fatigue syndrome

Deep vein thrombosis

Depression

Diabetes

Digestive disorders

Drug addiction

Epilepsy

Fibromyalgia

Gall stones

HIV

Heart condition

Hemophilia

High/Low blood pressure

Jaw pain

Kidney disease/stones

Liver condition

Migraines

Multiple sclerosis

Osteoporosis

Pacemaker

Respiratory condition

Rheumatic fever

Sinus problems

Skin condition

Spinal injury

Sprains or fractures

Stroke

Thyroid problem

Tuberculosis

Ulcers

Ulcerative Colitis

Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all Medications, Herbs, Vitamins and Supplements:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List past injuries, hospitalizations or surgeries with approximate dates (unless already noted previously:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_

Do you have any allergies (medications, environmental, etc)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you frequently use any of the following (please check yes or no):

 Yes No If yes, how often

Painkillers \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Antacids \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Laxatives \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Birth control pills \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Yes No If yes, form and how often

Tobacco \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Recreational drugs \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lifestyle:**

Describe your diet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you crave any particular foods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise: Y N If yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stress level: Low - 1 2 3 4 5 6 7 8 9 10 - High

Physical symptoms when stressed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleep: Hours per night: \_\_\_\_\_\_\_\_\_\_\_ Rested in AM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Trouble falling asleep: \_\_\_\_\_\_\_\_\_\_\_ Trouble staying asleep: \_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Enjoy work: Y N

Hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have children (if so what age): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptom Survey** (please check all that apply):

**0= Never 1= Rarely 2= Occasionally 3= Frequently 4= Always**

0 1 2 3 4 low appetite

0 1 2 3 4 loose stools

0 1 2 3 4 gas/ abdominal bloating

0 1 2 3 4 fatigue after eating

0 1 2 3 4 hemorrhoids

0 1 2 3 4 bruise easily

0 1 2 3 4 anemia

0 1 2 3 4 ravenous appetite

0 1 2 3 4 heartburn/ acid reflux

0 1 2 3 4 mouth sores

0 1 2 3 4 belching or vomiting

0 1 2 3 4 gums bleeding/swollen

0 1 2 3 4 thirst Hot? Cold?

0 1 2 3 4 bad breath

0 1 2 3 4 abnormal swelling

0 1 2 3 4 allergies

0 1 2 3 4 asthma

0 1 2 3 4 shortness of breath

0 1 2 3 4 cough

0 1 2 3 4 dry nose/mouth/skin/throat

0 1 2 3 4 fatigue

0 1 2 3 4 catch colds easily

0 1 2 3 4 tired after little exertion

0 1 2 3 4 general weakness

0 1 2 3 4 nasal discharge

0 1 2 3 4 sinus congestion

0 1 2 3 4 sore, cold or weak knees

0 1 2 3 4 low back pain

0 1 2 3 4 frequent urination

0 1 2 3 4 urinary incontinence

0 1 2 3 4 ear/hearing problems

0 1 2 3 4 early morning diarrhea

0 1 2 3 4 feel cold often

0 1 2 3 4 swollen ankles

0 1 2 3 4 poor memory

0 1 2 3 4 hair loss

0 1 2 3 4 infertility

Low Normal High libido

0 1 2 3 4 irritable

0 1 2 3 4 ligament/tendon issues

0 1 2 3 4 tight feeling in chest

0 1 2 3 4 alternate diarrhea/constipation

0 1 2 3 4 sigh frequently

0 1 2 3 4 neck/shoulder tension

0 1 2 3 4 muscle spasms/twiches

0 1 2 3 4 numb extremities

0 1 2 3 4 dry, irritated eyes

0 1 2 3 4 ear ringing

0 1 2 3 4 anger easily

0 1 2 3 4 red eyes

**0= Never 1= Rarely 2= Occasionally 3= Frequently 4= Always**

0 1 2 3 4 feel heart beating

0 1 2 3 4 insomnia

0 1 2 3 4 sores on tip of tongue

0 1 2 3 4 anxiety

0 1 2 3 4 chest pain

0 1 2 3 4 disturbing dreams

0 1 2 3 4 restlessness

0 1 2 3 4 palpitations

0 1 2 3 4 dizzy upon standing

0 1 2 3 4 floaters in eyes

0 1 2 3 4 heat in palms or soles

0 1 2 3 4 afternoon fever

0 1 2 3 4 night sweats

0 1 2 3 4 flushed face

0 1 2 3 4 feeling of heaviness

0 1 2 3 4 nausea

0 1 2 3 4 foggy thinking

0 1 2 3 4 enlarged lymph nodes

0 1 2 3 4 cloudy urine

**Urination:** Circle all that apply: Burning Urgent Scanty Difficult

 Profuse Dribbling More than 1 time a night

**Bowel movements:** Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_

Consistency (circle): Well-formed Hard Loose Alternates

Do you ever have (circle): Undigested food Blood Mucous

Do you prefer beverages that are: Warm Cold Room temperature

Do you find that you tend to be particularly hot or cold: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is your energy level in general: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Women Only:**

Are you currently pregnant: Y N Unsure

# of pregnancies \_\_\_\_\_\_ # of live births \_\_\_\_\_\_\_ # of miscarriages \_\_\_\_\_\_

How old were you when you had your first period: \_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced menopause: Y N When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you experiencing perimenopausal symptoms, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vaginal discharge: Y N Clear/White/Yellow/Green Itch/Burn/Pain/Foul Odor

Is your period regular: \_\_\_\_\_\_\_\_\_\_ When was the first day of your last period: \_\_\_\_\_\_\_\_\_\_\_\_\_

Length of cycle (start of one period to start of the next): \_\_\_\_\_\_\_\_

Average number of days of flow: \_\_\_\_\_\_\_\_\_ Flow: Light Normal Heavy

Colour (circle all that apply): Pale Normal Dark Bright Red Brown Purple

Blood clots: Y N

Cramps: Y N Severe: Y N

Type of pain: Sharp Dull Constant Intermittent Burning Aching

Do you experience any of the following before or during your period:

Breast Swelling/tenderness Water retention Depression Irritability Headaches

 Insomnia Diarrhea Constipation Nausea Hot flashes Night sweats

**Men Only:**

Circle all that apply:

Groin pain Enlarged prostate Decreased libido Testicular pain Impotence

Painful urination Difficult urination Premature ejaculation Nocturnal emissions

Increased libido

**Informed Consent for Acupuncture Treatment**

***PLEASE NOTE THAT THIS FORM MUST BE SIGND PRIOR TO YOUR FIRST APPOINTMENT***

Traditional Chinese Medicine is a system of healthcare that takes a holistic and natural approach to assessment, diagnosis, and treatment with a focus on prevention, restoration and health maintenance.

Traditional Chinese Medicine includes the use of acupuncture, botanical formulas, and dietary changes to eliminate disease and to balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tinctures, or decoctions (strong teas) to be taken internally or used externally as a wash. Dietary advice is based on traditional Chinese medical theory.

It is very important that you inform your acupuncturist immediately of any disease process that you are suffering from and any medications/over the counter drugs that you are currently taking. Please advise your acupuncturist if you are pregnant, suspect you are pregnant or if you are breast-feeding.

As with any form of medical intervention there can be health risks associated with treatment by naturopathic medicine. These include but are not limited to aggravation of pre-existing symptoms, fainting, pain, bruising or injury from acupuncture needles.

**Acupuncture Pricing and Fee Policy**

|  |  |  |
| --- | --- | --- |
| **SERVICE** | **PRICE** | **DURATION OF VISIT** |
| Initial Visit | $110 | 60 minutes |
| Follow-up Visit | $60 | 30 minutes |

|  |  |
| --- | --- |
| Initial | I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent unless required by law. |

|  |  |
| --- | --- |
| Initial | I understand that the acupuncturist will answer my questions to the best of her ability. I understand that the results are not guaranteed. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. |

|  |  |
| --- | --- |
| Initial | I understand that fees are to be paid for at the time of consultation and that I am responsible for submitting all claims to my extended health care provider. |

|  |  |
| --- | --- |
| Initial | I understand that a Missed Appointment Fee of $30 will be charged for any missed appointments or cancellations with less than 24 hrs notice. Unforeseen circumstances will always be taken into consideration. |

|  |  |
| --- | --- |
| Initial | I understand that NO supplement or herbal recommendations will be made during an acupuncture visit. Supplement and herbal recommendations can only be made during Naturopathic visits, and can only be done after an initial Naturopathic visit. |

I have read and understand the above-stated policies. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent at any time.

Patient Name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_