DeLand Community Acupuncture New Patient Intake

Name _____ DOB _____

Full Address _____

Phone # _____ Email _____

Have you had acupuncture before? _____ How did you hear about our clinic? _____

Please fill in the blanks and circle the underlined options that apply best to you.

PRIMARY complaint (list no more than two): _____

I have had this complaint for _____ days / weeks / months / years. It comes and goes / is constant.
It is relieved with heat / cold / rest / movement / massage. It is worse with heat / cold / rest / movement / massage.

- I tend to be too hot / cold. I experience hot flashes / night sweats / excessive sweating / inability to get warm.
- I sleep well / poorly. I have trouble falling / staying asleep. I am often / rarely fatigued.
- I rarely / often have congestion. I have coughing / runny nose / phlegm in my throat / shortness of breath.
- I have dry eyes / dry skin / a diagnosed skin condition: _____
- My digestion is good / poor. I often have nausea / vomiting / acid reflux / bloating / diarrhea / constipation.
- I am often / rarely in pain. The pain is constant / comes and goes. Pain location: _____
- I have high / moderate / low stress. I often / rarely get time to do things I enjoy.
- I often / rarely have headaches. The headache is located: top / back / sides / temples / sinuses / forehead.
- I have been diagnosed with high blood pressure / hypothyroid / hyperthryoid / diabetes / apnea / asthma.
- I smoke _____ packs of cigarettes per day. I have _____ alcoholic beverages per week.

Please answer the following questions only if they apply to you.

- I experience no / minor / severe symptoms of PMS. I experience cramping / mood swings / irregular cycle / clots / abnormal bleeding. Current day in cycle _____. Average number of days in cycle _____.
- I am not pregnant / pregnant. I am menopausal / post-menopausal.
- I am taking natural / synthetic hormones.
- I experience impotence / premature ejaculation.

Please list medications, surgeries, and diagnosed medical conditions on the back of this form.

Informed Consent and Financial Policy

- I hereby request and consent to the performance of acupuncture or other modalities within the scope of practice of Oriental Medicine on me by MacKenzie Lea Muir, AP, who is licensed by the state of Florida to practice acupuncture.
- I understand that there are some risks to treatment, including but not limited to some bruising and/or slight bleeding, some pain at the side of the needle insertion, dizziness or fainting, or possible aggravation of symptoms existing prior to treatment. The risk infection is very slight as all needles used are pre-sterilized, single-use, and disposable.
- I have had the opportunity to discuss with MacKenzie Lea Muir, AP, the nature and purpose of acupuncture. I understand that results are not guaranteed. I do not expect MacKenzie Lea Muir, AP, to be able to anticipate and explain all outcomes and risks. I understand that I may stop treatments at any time. I understand that the evaluation given to me is an energetic assessment based on the theories of Oriental Medicine. I understand that MacKenzie Lea Muir, AP, is not providing Western (allopathic) medical care, and that I should look to my primary care practitioner for those services and routine check-ups.
- Payment is expected at the time of treatment. The cost of an acupuncture treatment is payable on a sliding scale of $15.00-$35.00, plus a one-time fee of $10.00 due at the first visit. Unless canceled at least 12 hours in advance, our policy is to charge $15.00 for missed appointments.
- I have read the above consent and financial policy. I have had the opportunity to ask questions, and by signing I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature _____ Date _____

Emergency Contact Name and Number _____