Name _____ DOB _____

Full Address _____

Phone # _____ Email _____

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

*****Please list all medications, supplements, and surgeries on the back of this page.*****

What is your **primary** reason for coming for acupuncture? _____

How long have you had this issue? _____ Rate your pain / discomfort on a scale of 1 to 10: _____

What is your **secondary** reason for coming for acupuncture? _____

How long have you had this issue? _____ Rate your pain / discomfort on a scale of 1 to 10: _____

*****Please list all medications, supplements, and surgeries on the back of this page.*****

Please mark all symptoms that apply.

- ☐ hypertension
- ☐ hypotension
- ☐ high cholesterol
- ☐ hypothyroid
- ☐ hyperthyroid
- ☐ diabetes
- ☐ sleep apnea
- ☐ asthma
- ☐ osteoarthritis
- ☐ rheumatoid arthritis
- ☐ fibromyalgia
- ☐ celiac disease
- ☐ hysterectomy
- ☐ Parkinson's
- ☐ stroke
- ☐ IBS
- ☐ shingles
- ☐ cancer _____
- ☐ skin condition _____
- ☐ other diagnosed medical condition _____

- ☐ high stress
- ☐ anger/frustration
- ☐ sadness
- ☐ worry/overthinking/anxiety
- ☐ excessive fear
- ☐ forgetfulness/distracted

- ☐ hot flashes/night sweats
- ☐ excessive sweating
- ☐ cold hands/feet
- ☐ often cold
- ☐ often hot

- ☐ trouble falling asleep
- ☐ trouble staying asleep
- ☐ fatigue during the day

- ☐ acid reflux/heartburn
- ☐ nausea
- ☐ vomiting
- ☐ bloating
- ☐ constipation
- ☐ diarrhea
- ☐ painful urination
- ☐ frequent urination

- ☐ generalized muscle pain
- ☐ generalized joint pain
- ☐ heaviness in the limbs
- ☐ headaches/migraines
- ☐ neck pain
- ☐ shoulder pain
- ☐ arm pain
- ☐ elbow pain
- ☐ hand/finger pain
- ☐ low back pain
- ☐ mid back pain
- ☐ upper back pain
- ☐ hip pain
- ☐ leg pain
- ☐ knee pain
- ☐ foot/toe pain

- ☐ vegan/vegetarian
- ☐ gluten or dairy free (circle)
- _____ oz water per day
- ☐ smokes _____ per day
- ☐ alcohol _____ per day

- ☐ chronic runny nose
- ☐ chronic congestion
- ☐ seasonal allergies
- ☐ food allergies
- ☐ phlegm in throat
- ☐ chronic cough
- ☐ shortness of breath
- ☐ dry or watery eyes (circle)

- ☐ premature ejaculation
- ☐ impotence

- ☐ severe PMS
- ☐ heavy menstrual bleeding
- ☐ irregular menstrual cycle
- ☐ cramping
- ☐ clotting
- ☐ menopausal
- ☐ postmenopausal
- ☐ pregnant
- ☐ current day of cycle _____ out of _____ total days

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 in 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 site of the needle insertion, dizziness or fainting, or possible aggravation of existing symptoms. 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 assessment based on the theories of Oriental Medicine. I understand that MacKenzie Lea Muir, AP, is not providing Western medical care, and that I should look to my primary care practitioner for those services. 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 _____