Community Acupuncture of Orlando 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.

What is your PRIMARY complaint? ____

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.
- I sleep well / poorly. I am often / rarely fatigued.
- I rarely / often have allergies / congestion. I have coughing / runny nose / phlegm in my throat.
- 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 myself for relaxation.
- I often / rarely have headaches. The headache is located: top / back / sides / temples / sinuses / forehead.
- My blood pressure is high / low. I have been diagnosed with hypothyroid / hyperthyroid / diabetes / apnea.

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 by the A.P.s of Community Acupuncture of Orlando (CAO) who are 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 site of the needle insertion, dizziness or fainting, or possible aggravation of symptoms existing prior to treatment. The risk of infection is very slight as all needles used are pre-sterilized, single-use, and disposable. I understand that the zero gravity chairs in the treatment room will hold no more than 220 pounds.
I have had the opportunity to discuss with my acupuncturist the nature and purpose of acupuncture. I understand that results are not guaranteed. I do not expect my acupuncturist 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 my acupuncturist 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. 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 ____