ARROWHEAD ACUPUNCTURE & HOLISTIC HEALTH

29135 Hook Creek Road, Cedar Glen, CA 92321 | arrowhead.acupuncture@gmail.com
Office: 909-485-1616 | mailing address: PO Box 241, Cedar Glen, CA 92321

CONFIDENTIAL NEW PATIENT INTAKE FORM

NAME_____ GENDER_____ D.O.B._____ AGE____

MAILING ADDRESS _____
_____
_____
REFERRED BY _____

CELL # _____ OK TO TEXT? Y N
E-MAIL _____
EMERGENCY CONTACT_____
PHONE _____

Height _____ Current weight _____ Weight you feel best at _____

Marital Status _____ Number of Children _____ Occupation _____ Hrs/wk _____

Have you had acupuncture before? Y N Condition treated _____ Effective? Y N

Main reason you are seeking treatment today _____

Onset _____ Getting worse _____ Effecting: Work _____ Sleep _____ Other _____

Other therapies you are currently using for this condition, including Practitioner's name, phone #, and how often
_____
_____

Primary MD, name and phone _____

Exercise/Physical Activity _____ How often? _____

Is your condition worse/better after: activity _____ after rest _____ Do you tend to feel hot or cold?_____

Prescription Medications and Supplements	Dosage	When did you start taking them?

Current medical conditions _____
_____

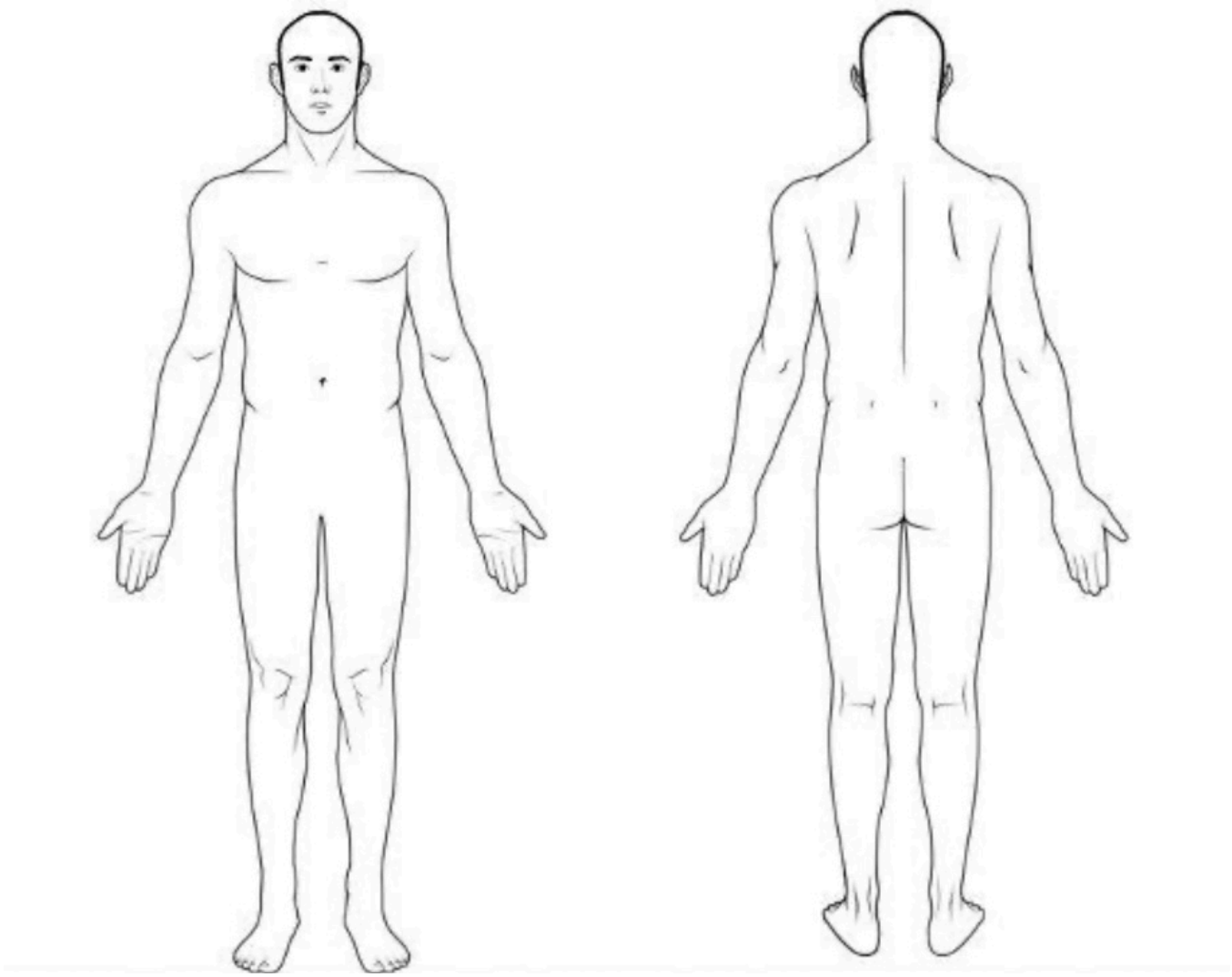
Any contagious diseases? Y N HIV_____ HEP A, B, or C _____ Other _____ Date contracted _____

Past medical conditions by date, from most recent _____
_____

Familial medical conditions/causes of death _____

Allergies to corn, potato, other (please list) _____

Using the following marks, please illustrate on the diagram any areas you have:
pain (xxx), numbness (///), weakness (+), and/or stiffness (000)



How would you describe the pain? (i.e. sharp, dull, etc.) _____

Where would you put this pain on a scale of 1-10 now _____ **at its worst** _____ **average** _____

Are you applying ice/heat? How often? _____

Are you using painkillers? Y N If you answered yes, how much? _____ **How often?** _____

External Applications _____

Past surgeries by date from most recent _____

_____

_____

Proposed surgeries and dates _____

Other _____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient names below, for whom I am legally responsible) by the acupuncturist(s) who, now or in the future, treat me.

I understand the methods of treatment may include, but are not limited to, acupuncture, Chinese herbal medicine, and nutritional counseling. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff if any unanticipated or unpleasant effects associated with the consumption of herbs. I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plants, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs many be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment, which the clinical staff thinks at the time, based upon the facts them known, is in my best interest. I understand that results are not guaranteed. I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent of treatment, have been told about my risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future

I hereby give consent for Lucas Hausler to discuss my case with my other doctors previously listed: initial _____

I understand there is a $50 charge for any cancelations within 24 hours of scheduled appointments: initial _____

PATIENT PRINTED NAME _____

PATIENT SIGNATURE _____ DATE _____

PARENT OR GUARDIAN PRINTED NAME _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____