ACUPUNCTURE ATLANTA
INTAKE FORM

Name:_____ Today's Date:_____

Name of Parent/Guardian (if under 18):_____

Address:_____

City: _____ State: _____ Zip:_____

Primary Phone: (_____)_____-_____ Email:_____

Birthdate: _____ Sex: ___Female ___Male

Relationship Status: ___Single ___Married ___Domestic Partnership ___Divorced ___Widowed ___Other

Occupation: _____ Employer: _____

Referred by (if any): _____

Emergency Contact Information:

Name:_____

Primary Phone: (_____)_____-_____ Alternate Phone: (_____)_____-_____

Relation to you: _____

Briefly describe your present health concerns and/or areas of distress:

Physical: _____

Emotional: _____

Emotional: _____

Other Concerns: _____

Current Medications: (both prescription and non) _____

_____

Have you ever been tested for HIV? ___Yes ___No

Results? ___Positive ___Negative

Do you have any surgical implants? ___Yes ___No

What kind? _____

List any current therapies or treatments:

Start Date:	Therapies or Treatment Modality:	City & State
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any healthcare providers you have consulted in the past 3 years:

Name:	Field/Specialty:
_____	_____
_____	_____
_____	_____

MEDICAL HISTORY

Please Check any of the following symptoms you currently or have previously experienced:

VERY IMPORTANT INFORMATION

__Pacemaker __Metal Support __Infectious Disease

Musculoskeletal & Nervous System

__Sore Muscles __Aching muscles __Weak muscles __Tight muscles __Muscle Cramps
__Muscle jerking __Bursitis __Arthritis __Scoliosis __Headaches
__Migraine Headaches __Numbness/tingling __Paralysis __Convulsions/Seizures __Head Injury
__Recently knocked Unconscious

Broken bones:_____

Bone or joint disease:_____

Recurrent dislocations:_____

Other Injuries:_____

Digestive System and Abdomen

__Poor appetite __Excessive appetite __Irregular appetite __Change in eating habits
__Change in appetite __Nausea __Abdominal pain __Indigestion
__Heartburn __ "Nervous stomach" __Ulcers __Vomiting: Food Blood Bile
__Black stool __Bloody stool __Fatty Stool __Change in gas / belching
__Diarrhea __Constipation __Hemorrhoids __Bleeding hemorrhoids
__Hemorrhoids-piles __Rectal bleeding __Parasites __Worms
__Hepatitis __Liver problems __Gallbladder problems __Pancreas problems
__Ulcers __Hernia: Abdominal Inguinal Hiatal

Heart and Circulation

__Chest pain __Rapid heart beat __Slow heart beat __Irregular heart beat __Pain over heart
__High blood pressure __Low blood pressure __Varicose veins __Swelling/edema __Ankle swelling
__Hand swelling __Pain in calf while walking

Other heart problems: _____

Skin, Hair & Nails

__Itchy skin __Sensitive skin __Rash __Bruise easily
__Excessive perspiration __Deficient perspiration __Premature gray hair

Nail problems: _____

Other hair/scalp problems:_____

Reproductive System

__Vaginal discharge __Vaginal pain __Abnormal Vaginal bleeding __Breast tenderness
__Breast lumps __Breast discharge __Menstrual related mood changes __Menstrual cramps
__Menopause problems __Hot flashes __Menstrual flow: Heavy Medium Light
__Genital lesions __Hernia __Testicular mass or lump __Testicular pain
__Prostate problems __Erectile problems __Ejaculation problems

Length of menstrual cycle (start to start days):_____ Date of last period (1st day)_____

Number of pregnancies:_____ Number of Children:_____

Reproductive System (continued)

Birth control method:_____

Sexual difficulties:_____

Kidney & Bladder

__Painful urination __Blood in urine __Frequent urination __Urgent urination
__Difficult urination __Lack of bladder control __Wake to urinate __Bedwetting
__Excessive urine __Scanty urine __Strong odor in urine __Discolored urine
__Urethral discharge __Urinary infection __Kidney stones __Intermittent urination

Other related problems:_____

Respiratory System

__Difficulty breathing __Painful breathing __Persistent cough __Coughing of phlegm
__Coughing of blood __Hyperventilation __Asthma/wheezing at night __Chronis sinus congestion
__Infrequent sinus congestion __Asthma/wheezing on exertion __Shortness of breath on exertion __Shortness of breath at night

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Eye, Ear, Nose, Throat & Mouth

__Eye strain __Eye inflammation __Blurred vision __Ear pain __Ringing in ears
__Ear discharge __Loss of hearing __Loss of sight __Loss of taste __Loss of smell
__Nose pain __Nose bleeding __Nose discharge __Sore throat __Hoarseness
__Difficulty swallowing __Difficulty w/ speech __Difficulty w/ chewing __Teeth problems __Gum problems
__Mouth ulcers __Bad taste in mouth __Excessive saliva __Deficient saliva
__Difficulty breathing from nose during day __Difficulty breathing through nose at night

Other vision problems:_____

Tongue Problems:_____

Miscellaneous

__Thyroid problems: Hypo or Hyper __Rapid weight gain __Rapid weight loss __Heat & cold intolerance
__Cold hands and feet __Excessive thirst __Slow to heal __Enlarged glands __Water retention
__Tire easily __General fatigue __Poor memory __Dizziness __Fainting
__Fever __Chills __Night sweats __Shaky feelings __Confusion
__Irritability __Depression __Anxiety __Emotional breakdown __Cry easily
__Anemia __Dehydration __Difficulty concentrating

Indicate if you have been diagnosed with any of the following:

__Cancer __Diabetes __Hypoglycemia __STD
__Mononucleosis __HIV/AIDS __CMV __Epstein-Barr

Allergies (food and other):_____

_____

Favorite foods: _____

Significant medical history (illnesses, surgeries, injuries) birth to present not yet mentioned:

_____

_____

_____

Current weight: _____ Weight 1 year ago:_____

Max weight: _____date:_____

Indicate if you have ever had surgery involving any of the following:

__Appendix __Gallbladder
__Ovary(ies) __Uterus Other surgeries:_____

Have you ever had a blood transfusion? Yes No Type: __Blood __Plasma Year:_____

Indicate if you have ever had x-rays done on any of the following:

	Yes	No
Back	___	___
Neck	___	___
Extremities	___	___
Chest	___	___
Gallbladder	___	___
Colon	___	___
Stomach	___	___

Other x-rays: _____

Have you ever had a CT scan? Yes No Have you ever had an MRI? Yes No

Personal Habits

Yes	No		Yes	No	
___	___	Do you sleep well? Hours of sleep per night: _____	___	___	Do you read? Hours read per day: _____
___	___	Awaken Rested?	___	___	Do you take vacations?
___	___	Do you have regular bowel movements?		_____	Weeks of vacation per year
___	___	Sex satisfactory?	___	___	Have you been treated for alcoholism?
___	___	Do you like your work?	___	___	Have you been treated for drug abuse?
___	___	Do you watch tv? Hours watched per day:_____			
___	___	Do you participate in sports/hobbies for at least 3 hrs. per week?			
___	___	Do you exercise? Describe your exercise:_____			

_____

_____

What types of stress are you under?_____

What do you do to relieve stress?_____

How often do you use the following?

	Never	Occasionally	Frequently
Vitamins	___	___	___
Sedatives/Tranquilizers	___	___	___
Laxatives	___	___	___
Aspirin, etc.	___	___	___
Appetite Suppressant	___	___	___
Sleeping Pills	___	___	___
Coffee/Tea	___	___	___
Cups per day	_____		

	Never	Occasionally	Frequently
Alcoholic Beverages	___	___	___
Recreational Drugs	___	___	___
Cigar or Pipe	___	___	___
Chewing Tobacco/Snuff	___	___	___
Marijuana	___	___	___
Soft Drinks	___	___	___
Cigarettes	___	___	___
Packs per day:	_____		

Briefly describe other significant health problems and concerns not listed on this questionnaire:

_____

_____

Family History

For your mother, father, siblings, children and spouse, check applicable illnesses:

	Mother	Father	Sister	Brother	Children	Spouse
Tuberculosis	___	___	___	___	___	___
Diabetes	___	___	___	___	___	___
Heart Trouble	___	___	___	___	___	___
High Blood Pressure	___	___	___	___	___	___
Stroke	___	___	___	___	___	___
Epilepsy	___	___	___	___	___	___
Emotional Crisis	___	___	___	___	___	___
Asthma, Hives, Hay Fever	___	___	___	___	___	___
Cancer	___	___	___	___	___	___
Type of Cancer:						
Death	___	___	___	___	___	___
Year:						
Cause:						

INFORMED CONSENT TO TREAT

Acupuncture Atlanta
ACUPUNCTURE CLINIC

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture, Dry Needling, and Massage Therapy are not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments, dry needling, massage therapy, and other procedures within the scope of the practice of acupuncture and massage on me (or on the patient named below, for whom I am legally responsible) by the licensed providers who now or in the future treat me, including those working at Acupuncture Atlanta.

I understand that methods of treatment may include, but are not limited to, acupuncture, dry needling, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), massage therapy, Chinese herbal medicine, supplements and nutraceuticals, and nutritional counseling. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of an herb, supplement, and/or nutraceutical.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture, dry needling, and massage therapy are generally safe methods of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include 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 plant, 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 may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my provider and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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 then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). 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.

I understand that there are treatment options available for my condition other than acupuncture, dry needling, and massage therapy procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture, dry needling, massage therapy, and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment for with Acupuncture Atlanta.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ _____

(Or Patient Representative) (Indicate relationship if signing for patient) (Date)

ACUPUNCTURE ATLANTA

24 HOUR CANCELLATION POLICY

Acupuncture Atlanta has a 24 hour cancellation/ rescheduling policy.

If you miss your appointment, cancel or change your appointment with less than 24 hours' notice, you will be charged $45.

This policy is in place out of respect for our therapists and our clients. Cancellations with less than 24 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Acupuncture Atlanta as described above.

Thank you for your understanding and cooperation.

_____ _____

Print Name Signature

_____

Date

WAIVER OF LIABILITY RELATING TO COVID 19/CORONAVIRUS

Please read carefully:

Acupuncture Atlanta cannot prevent you [or your child(ren)] from becoming exposed to, contracting, or spreading COVID-19 while utilizing [Acupuncture Atlanta]'s services or premises. It is not possible to prevent against the presence of the disease. Therefore, if you choose to utilize Acupuncture Atlanta's services and/or enter onto Acupuncture Atlanta's premises you may be exposing yourself to and/or increasing your risk of contracting or spreading COVID-19.

ASSUMPTION OF RISK: I have read and understood the above warning concerning COVID-19. I hereby choose to accept the risk of contracting COVID-19 for myself and/or my children in order to utilize Acupuncture Atlanta's services and enter Acupuncture Atlanta's premises. These services are of such value to me [and/or to my children,] that I accept the risk of being exposed to, contracting, and/or spreading COVID-19 in order to utilize Acupuncture Atlanta's services and premises in person.

WAIVER OF LAWSUIT/LIABILITY: I hereby forever release and waive my right to bring suit against Acupuncture Atlanta and its owners, independent contractors, directors, managers, officials, trustees, agents, employees, or other representatives in connection with exposure, infection, and/or spread of COVID-19 related to utilizing Acupuncture Atlanta's services and premises. I understand that this waiver means I give up my right to bring any claims including for personal injuries, death, disease or property losses, or any other loss, including but not limited to claims of negligence and give up any claim I may have to seek damages, whether known or unknown, foreseen or unforeseen.

CHOICE OF LAW: I understand and agree that the law of the State of **Georgia** will apply to this contract.

I HAVE CAREFULLY READ AND FULLY UNDERSTAND ALL PROVISIONS OF THIS RELEASE, AND FREELY AND KNOWINGLY ASSUME THE RISK AND WAIVE MY RIGHTS CONCERNING LIABILITY AS DESCRIBED ABOVE:

Signature: _____ Date:_____

Name (printed): _____

I am the parent or legal guardian of the minor named above. I have the legal right to consent to and, by signing below, I hereby do consent to the terms and conditions of this Release.

Signature : _____ Date: _____

Name (printed) _____