MEDICAL ACUPUNCTURE INTAKE FORM

Name Last _____ First _____ Middle _____

Date of Birth ____ / _____ / _____ **Gender** F / M / B SSN# _____

Address _____ City _____ State _____

Zip code _____ Email _____

Telephone: Home (_____)_____ Work (_____)_____

Cell phone (_____)_____ preferred method of contact _____

Marital status _____ Education level _____

Occupation _____ Employer _____

Have you ever been treated with Acupuncture before? _____

Name of your Primary Care Physician: _____

Address of your physician: _____

Telephone number of your physician: _____

Emergency contact/phone #: _____

Height _____ Weight _____ HIV/HepB/HepC status _____

Are you pregnant? _____

Do you smoke? Y / N If so, what and how much? _____

Do you drink alcohol? Y / N How often and how much? _____

Do you drink coffee? Y / N How much? _____

Do you exercise? Y / N How frequently and what type? _____

MEDICAL ACUPUNCTURE INTAKE FORM

What are your goals for acupuncture treatment? _____

_____

MAIN ISSUE FOR WHICH YOU ARE SEEKING TREATMENT (please attach sheet if extra room is needed):

_____

_____

Have you seen a physician/care provider for this previously? _____

What treatment has been tried? _____

_____

How did it start? _____ When? _____

PAST MEDICAL DIAGNOSES/TREATMENT (please attach form if extra space needed):

_____

_____

_____

_____

_____

PAST SURGICAL HISTORY (Surgery and date or year):

1) _____

2) _____

3) _____

FAMILY HISTORY OF ILLNESS/DISEASE:

_____

ALLERGIES : _____

_____

SIGNIFICANT PHYSICAL TRAUMA/INFECTIOUS DISEASE: _____

_____

_____

MEDICATION LIST (please include dosage):

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

SUPPLEMENT LIST (which/how often/for what condition or symptom. Please attach extra sheet if more room is necessary)

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

PERSONAL HISTORY:

Childhood health _____

Emotional/psychological stress as a child _____

Current Emotional health _____

Current Predominant Emotion _____

Current life stressors _____

_____

Past life stressors
_____

_____

Quality of life _____

Any children? _____

Any pets? _____

Recent or frequent travel abroad? _____

_____

Hobbies & Recreational habits _____

_____

Food cravings/Dietary challenges _____

_____

Other: _____

_____

_____

CONSENT FORM FOR MEDICAL ACUPUNCTURE TREATMENT

I _____ consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture by Jennifer A Neff, M.D. now or in the future.

I understand that acupuncture treatment involves the use of acupuncture needles (small, sterile stainless steel needles). Treatment may also include use of electrical stimulation of needles, cupping, gua sha scraping and use of the herb Folium Artemesia Vulgaris (moxa). _____

I understand that complications of acupuncture treatment occur infrequently but may include: pain at the needle site, bruising and bleeding. Bleeding and bruising, may be more prevalent and more severe in patients using blood thinning medication. Uncommon complications of acupuncture treatment also include dizziness, fainting or infection. Very rare risks of acupuncture include spontaneous abortion, nerve injury and puncture of an organ. _____

I understand that light headedness or euphoria may occur briefly after treatment. I also understand that results of acupuncture are not guaranteed. _____

By my initials, I indicate understanding that Jennifer A. Neff, M.D. is functioning as a Medical Acupuncture Consultant and will not be providing the services of a primary care physician. _____

I understand that my records will be kept confidential and will not be released without my written consent. _____

I hereby state that I have read and understand this form. I wish to proceed with Medical Acupuncture treatment. I understand that I am free to withdraw consent at any time.

Signature of Patient or person authorized to consent on behalf of the patient:

Date