Health History & Intake Form

This is a confidential questionnaire to help determine the best individualized treatment plan for you.

COMMUNITY ACUPUNCTURE of Acadiana

Last Name	First Name	Middle Initial

What name would you like to be used ? (Ex: Jennifer, Jenny, Ms. Jenny, Sis)	Cell Phone:
Address:	Other Phone:
City, State, Zip Code	Gender:
Email Address:	Occupation:
May we use your email address for the following? regarding your course of treatment Yes No for automated appointment reminders Yes No for promotions & special events Yes No (Note: Your email address will not be used for any other purposes)	Age: _____ Date of Birth: _____/_____/_____
With your healthcare privacy in mind, what is the best way to reach you?	Relationship Status:
How did you hear about us?	
Do you use social media? Yes No If so, what's your preference? Facebook Twitter You Tube (circle all that apply)	
Family Physician:	Date of Last Check Up:
Physician's Phone Number:	
In case of emergency, please contact (Name and Phone #):	

What can we help you with today?

How long have you had this condition?
O Days O Weeks O Months O Years

Onset of condition: O Gradual O Sudden

Have you seen a doctor for this condition? O Yes O No

If yes, what diagnosis did you receive?

Please describe your hopes and expectations for acupuncture in this clinic:

Today's Date_____

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Authorization and Consent

While receiving acupuncture treatment, please feel free to communicate with the therapist what you experience during the needling process, as this will enable him to adjust needles and the points selected to maximize your comfort during treatment.

If you experience dizziness, nausea, cold, shortness of breath, or faintness during treatment, please let the therapist know immediately. This is known as needle shock, and while this occurrence is extremely rare, it helps to let the practitioner know if you experience any of these symptoms so that the needles can be removed. These symptoms go away immediately after needles are withdrawn, and are generally caused by anxiety when receiving acupuncture for the first time. Other possible side effects of acupuncture treatment may include: local bruising, mild pain in the area treated, brief generalized fatigue, tingling or numbness.

Everyone responds to treatment differently; therefore, we cannot guarantee the outcome of treatment. Some individuals experience total or partial relief of their pain or symptoms after the first few treatments. Others noticed steady, gradual improvement. In some cases, no relief is felt at all until after several days go by.

Occasionally, some people notice that their pain actually seems to be worse before it gets better. Let us know how you responded to the previous treatment at the time of your follow up visits or at the time you are contacted by email or text following your appointment so that your treatment plan can be adjusted accordingly. Depending on your condition and your goals for treatment, we may require you to consult a physician regarding the condition or conditions for which you are seeking acupuncture treatment. In addition, clients are responsible for seeking the advice and treatment of a physician should their symptoms change for the worse, or should any new condition arise.

_____ _____

Patient (Guardian) Signature Date of Signature

Patient Rights

The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.

The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.

In a professional caregiving relationship, sexual intimacy is never appropriate and should be reported to the Louisiana Board of Medical Examiners.

The Louisiana Board of Medical Examiners regulates the practice of acupuncture as described in the Louisiana Revised Statutes Title 37, Part IV- Statutes 1356-1359.