**Acupuncture Intake** **Date: _____**

Patient Name: Date of Birth:

Street Address: CELL/MOBILE PHONE:

City/State/Zip: Names/Ages of Children:

Email: Occupation:

_____ *INITIAL HERE*
that you understand there is a 50% CANCELLATION FEE for no shows or cancellations with less than 48 hour's notice.

List your EMERGENCY CONTACT here:
Is this your spouse/significant other/child/friend/neighbor/other contact?...CIRCLE ANSWER

List phone number of above listed 🔼 EMERGENCY CONTACT:

What is your main health complaint?

List any addtl. health complaints:

List any current health conditions: (asthma, anxiety, autoimmune, body pain, broken bones, car accidents,concussion history, headaches, heart issues, high BP, digestive issues, falls, sleep issues, thyroid disorders, INJURIES, etc…)

List any occasional or regular MEDICATIONS or VITAMINS/SUPPLEMENTS here:

| Medication | Rx used for |
| --- | --- |

List any broken bones, surgeries or hospitalizations:

Give an example of 2 typical breakfasts, 2 lunches and 2 dinners you eat:

**DO NOT WRITE BELOW THIS LINE**

| Beginning Pulses | | Ending Pulses | |
| --- | --- | --- | --- |
| F1/2 _____ | ME _____ | F1/2 _____ | ME _____ |
| WO _____ | EA _____ | WO _____ | EA _____ |
| WA _____ | F5/6 _____ | WA _____ | F5/6 _____ |

Tx Today:

Recommendations:

# Acupuncture Informed CONSENT TO TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist FELICIA M. DYESS and/or other licensed acupuncturists who now or in the future treat me while employed by or working in lieu of FELICIA M. DYESS.

I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (Chinese massage-bodywork), Chinese herbal medicine, and nutritional counseling in addition to energy work, Reiki and the positive emotion work created by Felicia M. Dyess herself. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. Any herbs may be unpleasant in smell and taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of recommended herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that I may have some side effects including bruising, numbness or tingling near the needle sites that may last a few days, as well as dizziness or fainting. Bruising can happen with both acupuncture and cupping. Unusual risks of acupuncture may include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture known as pneumothorax. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. 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 and should not be combined with other herbs. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will notify a member of the clinical staff if I am or become pregnant.

I do not anticipate the clinical staff to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgement during the course of treatment which the clinical staff thinks at the time, based on the facts then known is in my best interest. I understand that results are NOT GUARANTEED.

If I participate in community style acupuncture, I fully understand that I will be in a group setting with other patients which involves the risk of my private health information being heard or of hearing others private health information. I affirm that I will not discuss any other person's private information from my time in the Community Acupuncture setting and do not hold Felicia M. Dyess AP or members of her staff liable for any overhead private information.

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 I have had read to me, the above Consent To Treatment, and have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover my entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Patient's WRITTEN NAME:_____ DATE:_____

SIGNATURE OF Patient or Responsible Party:_____