

*Dr. John Whitaker*  
*Licensed Acupuncturist*

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ SS# \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Marital Status \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Referred By \_\_\_\_\_ Reason for your visit \_\_\_\_\_

Have you had acupuncture before? \_\_\_\_\_ Chinese Herb Medicine? \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Is it getting worse? \_\_\_\_\_

Does it bother your: Sleep \_\_\_\_\_ Work \_\_\_\_\_ Other? \_\_\_\_\_

What seems to be the initial cause? \_\_\_\_\_

What seems to make it better? \_\_\_\_\_

What seems to make it worse? \_\_\_\_\_

Are you under the care of a physician now? \_\_\_\_\_ If yes, for what? \_\_\_\_\_

Who is your physician? \_\_\_\_\_ Phone \_\_\_\_\_

Other concurrent therapies \_\_\_\_\_

**Health Insurance Info:**

Insurance Co Name \_\_\_\_\_ Policy # \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**Medicare Info:**

**Health Insurance Info:**

Insurance Co Name \_\_\_\_\_ Policy # \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

City, State, Zip \_\_\_\_\_

## Acupuncture Treatment Consent Form

I hereby request and consent to the performance of acupuncture treatment and other Oriental procedures. By the below signed acupuncturist and or other licensed acupuncturist, who now or in the future will treat me.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain dysfunctions in the body. This therapy is indicating for functional disorders of the musculoskeletal, respirator/gastrointestinal and neurological systems or even trauma.

I have been informed that acupuncture is a safe method of treatment but occasionally, there may be some side effects, such as burning or tingling near the needling sites that lasts a few days. There have been a very few reports of fainting or infection. Also there may be some bruising after cupping or needling.

According to Oriental Medical Theory, the body has twelve main meridians, through which energy or Qi flows. Blockages in flow of his energy (Qi) cause obstruction in the meridians, prohibiting the energy to flow freely. Pain is the main manifestation of meridian obstruction. Acupuncture treatment balances and moves the energy, therefore reinstating the free flow of Qi and reducing pain.

The clinic uses only Pre-sterilized individually packaged disposable needles. All acupuncturists employed by the clinic are certified in clean needle technique, to assure that infectious organisms are not transmitted during treatment.

I had discussed acupuncture and other procedures with the acupuncturist to be able to explain all the risks or complications. So I wish to rely on the acupuncturist to exercises his/her judgments, based on the, his or her knowledge, during the course of the procedure.

I understand the clinical and administrative staff may review my medical records and reports, but all my records will be kept confidential and will not be release without my written consent. I have also been advised of the importance of seeing a licensed physician for my condition.

I have read the above consent. I also have had an opportunity to ask questions about its contents by signing below I agree to acupuncture treatment. I intend this consent form to cover the entire course of treatment for this condition, or any other future conditions for which I may seek treatment.

Patient's name \_\_\_\_\_

Are you pregnant? \_\_\_\_\_

Name of Acupuncturist \_\_\_\_\_

We the undersigned do affirm that \_\_\_\_\_ has been advised by

\_\_\_\_\_ to consult a physician, regarding the condition for which such patient seeks acupuncture treatment.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Acupuncturist signature \_\_\_\_\_ Date \_\_\_\_\_