

Acupuncture Intake Form - New Moon Wellness

Name _____ Birthdate _____ Home Phone (____) _____

Street _____ Weight _____ Height _____ Cell Phone (____) _____

City _____ State _____ Zip _____ Work Phone (____) _____

Email Address _____ (add to preferred client list to receive promotional mailings?) YES NO

Physician _____

Occupation _____ Emergency Contact _____ Phone # (____) _____

Main Problem _____ Onset _____

Other Concurrent Therapies _____

Please check how you found us: Doctor/health care provider: please provide name _____

Alternative Practitioner: please provide name _____

Friend or family member: please provide name _____ Website: ____ Classes ____

In House Referral ____ Event ____ Walking by ____ Other _____

Past Medical History: (circle and include date)

Diabetes High Blood Pressure Heart Disease Hepatitis Seizures Cancer _____

Rheumatic Fever Thyroid Disease Other _____

Surgeries: _____

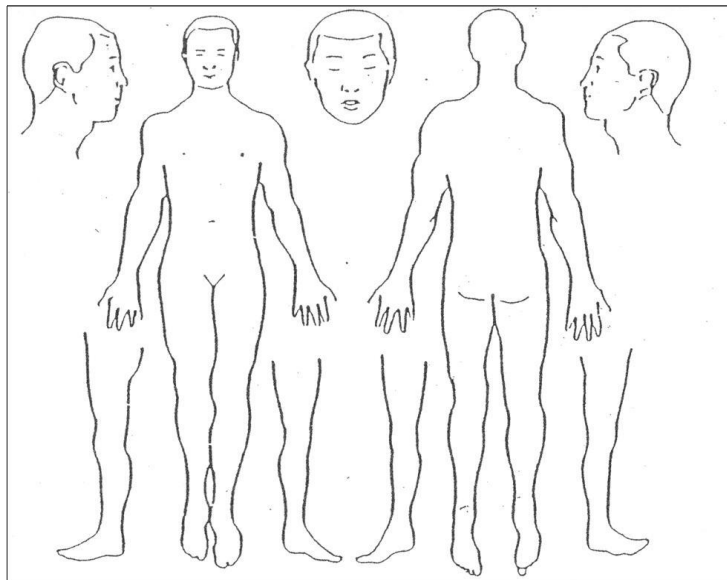
Significant Trauma: (auto accidents, falls, etc.) _____

Allergies: (drugs, chemicals, foods) _____

Medicines taken within the last two months: (including vitamins, over-the-counter drugs, herbs, etc.) _____

Mark areas affected by pain or discomfort on chart.

Please describe pain below or add other comments





CONSENT TO TREATMENT FORM

By signing below, I do hereby voluntarily consent to be treated with acupuncture and or/Traditional Chinese Medicine by acupuncturist Shannon Gyles.

Acupuncture/Moxabustion: I understand that acupuncture is performed by the insertion of sterile needles through the skin or by the application of heat to the skin (or both) at certain acupuncture points on or near the surface of the body in attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop receiving treatment at any time.

Chinese Herbal Therapy: I understand that substances from traditional Chinese Herbal Therapy may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administering dosage if I do decide to take them. I am aware that certain adverse side effects can result from taking these substances. These could include but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing before treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call New Moon Wellness as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-ma massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. They could include, but are not limited to: bruising, sore muscles or aches, pain or discomfort, and the possible aggravation of the symptoms existing prior to treatment. I understand I may refuse treatment.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse treatment.

Privacy Policy

The information received and collected about our clients/patients from their visit to New Moon Wellness is strictly private and confidential. It is used and viewed only by the healthcare professionals associated NMW, unless, in the best interest of the client/patient, a practitioner determines that there is a need to communicate with another person or healthcare professional outside of NMW. NMW will not give share or transfer any person information to a third party unless required by law. Under absolutely no circumstances will this communication happen without the signed consent of the client/patient. **Please notify us if you would like to receive a copy of our privacy Policy.**

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I also understand that my treatment cannot be used as a substitute for Western medical care.

I have carefully read all the above information and am fully aware of what I am signing. I understand that I may ask Shannon Gyles for additional information before signing this consent form.

I _____ have carefully read all the above information and am fully aware of what I am signing. I give my permission and consent to treatment.

Please sign name _____ Date _____

Signature witnessed by _____ Date _____

Parent signature _____ Date _____