ACUPUNCTURE
CENTER DECORAH

Name _____
(First) (Middle) (Last)

Gender: ____ Male ____Female

Date of Birth: _____Age:_____

Address: _____
Street

_____
City State Zip Code

Phone Numbers: Cell:_____

Home:_____

Work: _____

Email Address: _____

Occupation: _____

Employer: _____

Emergency Contact:

Name: _____

Relationship: _____

Phone: _____

Number of Children _____

Marital Status:

___ Single ___ Married ___ Divorced

___ Separated ___ Widowed

___ Domestic Partner ___ Other

Have you been to an acupuncturist before? Y/N

How did you hear about us? _____

_____

What are your most important health Concerns? _____

_____

_____

Major illnesses and hospitalizations with dates, illness/reason and outcomes:

_____

_____

_____

When were the dates of your last physical and blood work? _____

Current Medications/Supplements/Herbs _____

_____

Pregnancy: Are you currently pregnant?

_____yes _____no _____maybe

Health Habits:

Do you have high blood pressure? Y / N

Do you have high Cholesterol? Y / N

Do you have high blood sugar? Y / N

	What Form(s)	**Amount**	**How Often/How Long**
Alcohol			
Tobacco			
Caffeine			
Recreational Drugs			
Exercise			

Sleep: Do you sleep well? ___ yes ___ no : Average number of hours/day?____

Diet: Typical foods eaten: Breakfast: _____

Lunch:_____

Dinner:_____

Snacks: _____ Sweets:_____

Average amount of water you drink per day: _____

Family History:

Check if your blood relatives have had any of the following:	Relation	Age	Age at Death	Cause of Death
Arthritis, Gout				
Cancer				
Chemical Dependency (alcohol, drug)				
Heart Disease				
Thyroid Disease				

What can you expect on your first visit? Chinese medicines takes time to search for the underlying cause of your illness or symptoms and do not just provide you with symptomatic relief. Because of this, please be prepared to take the time necessary to give us a detailed history, to review body systems, and to design an individualized treatment plan for you. If you do not understand your treatment or are having problems with following your treatment plan, we encourage you to contact us so that we can help you appropriately.

Types of services rendered: Treatment techniques at Acupuncture Center Decorah include Acupuncture, Cranio-Sacral Therapy, Herbal Medicine, Homeopathy, Bodywork, Cupping, Moxa, Nutritional Counseling and Lifestyle advice.

Cancellation Policy: A minimum of twenty-four (24) hours advance notice is necessary for cancelling appointments. You will be billed the cost of the visit for missed appointments without 24-hour advance notice.

Payment is due at the time of treatment. We accept cash, checks, VISA, Discover, MasterCard and debit cards.

Signature_____ Date_____

CONSENT FORM

Consent for Treatment: I do hereby voluntarily consent to be treated with acupuncture and/or substances from Chinese Materia Medica administered by a licensed acupuncturist. I understand that acupuncturists are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended. I understand that treatment of any type may have side effects. I also understand that I have a right to stop treatment at any point and that it is my responsibility to inform my practitioner of my discomfort or preference to stop treatment. I understand that practitioners at Acupuncture Center Decorah are skillfully trained and are practicing with the intention of helping me in my healing process.

Consent for Release of Information: Release of information to physicians, referring physicians, insurers and professional review organizations: I authorize release of medical and related information, including alcohol and/or drug abuse and mental health records obtained in the course of diagnosis and treatment to the insured's insurance carrier(s), agencies and their intermediaries or carriers, if applicable, for the purpose of obtaining care, treatment or payment for service provided or to be provided. Administrative and non-medical patient data, including Social Security numbers may be included in released documents for the purpose of patient identification in compliance with state and federal agency reporting requirements, billing to insurance carriers and collection needs.

I have read and understand the above information.

I, the undersigned agree to pay for services at time of treatment.

I further agree to the discretion of the health care provider and give my consent for treatment.

Signature _____ Date_____

Parent or Guardian Signature_____