

DATE:

PATIENT INFORMATION		CONTACT INFORMATION
Name		Telephone
Address		Email
Age	Birthdate	Emergency Contact Name
Occupation		Emergency Contact Telephone
How did you hear about us?		

HEALTH HISTORY
What are your primary concerns for coming in for treatment? 1. 2.
List all medications or vitamins that your are currently taking.
List all serious illnesses, accidents, or surgeries in the last year.

Check symptoms that **CURRENTLY** apply:

- History of fainting
- Dizziness
- Fatigue
- Anemia
- Arthritis
- Cancer
- Diabetes
- Epilepsy/ Seizure Disorder
- Asthma
- Blurred/failing vision
- Hearing loss
- Ringing in ears
 - High pitch
 - Low pitch
- Cough
- Sore throat
- Fever
- Bruise easily
- Itching/rash
- Night sweats
- Tend to feel hot easily
- Tend to feel cold easily
- Known nickel allergy

- Blood in urine
- Low libido
- Chest pain
- High blood pressure
- Low blood pressure
- Diarrhea
- Constipation
- Indigestion/heartburn
- Nausea
- Stomach pain
- Vomiting
- Amenorrhea (period has stopped)
- Menopause
- History of Miscarriage
- PCOS
- Undergoing fertility treatments
 - Interested in day of transfer acupuncture information

Could you be pregnant?

Have you had acupuncture before?

By signing below I agree that the information on this form is correct to the best of my knowledge.

Signature
(Guardian Signature if Minor)

Patient's Name



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We Treat in a Community Room...

The treatment room is a quiet space for you and others. It is important to the clinic environment to maintain this reservoir of calm. Enjoy your AcuNap!

Community Space Acknowledgement

I understand that.....

- Community acupuncture is high volume a model, my acupuncturist may not look at my chart every time right before seeing me. I will tell the acupuncturist my symptoms each time.
- If I need to be woken up at a certain time, I will let my acupuncturist know.
- If other people's snoring bothers me, TCA has ear plugs available. Personal headphones may also be used so long as they aren't distracting to other patients. I will limit my screen time to music controls only.
- In a community space whispering and turning off my cell phone are necessary.
- I have the option to write down in a note any issues that I want to inform my acupuncturist of but do not want to speak about in a community setting.
- If I have a cough for any reason, I will be asked to wear a mask which TCA can provide.
- If I am experiencing flu-like symptoms (fever, nausea/vomiting, diarrhea, etc.) I will stay home and not come to TCA for acupuncture until I am well.
- Acupuncture needles are very small; and TCA needs to treat a high volume of patients in order to keep its prices low; and so I will do my required self check for needles before I leave my chair.

Patient's Name

Signature

Date



Allow yourself to disconnect! The treatment room is a **cell phone free** zone.

For privacy reasons there is absolutely **NO FACEBOOKING, TEXTING, WEB SURFING, GAMING, PHONE CALLS, OR TAKING PICTURES**, while in the treatment room. I will refrain from use of all phone activities other than as a personal music device. I understand I may use my phone only as a personal music device, and only as long as it is not distracting to others.

I understand the cell phone policy and I will turn my phone completely off, or put it in airplane mode, **BEFORE** entering the treatment room. I will not use my cell phone for texting, internet use, calls or camera use of any kind while in the treatment room.

Patient's Name

Signature

Date

Informed Consent to Acupuncture Treatment

I, the undersigned, hereby request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of Traditional Chinese Medicine. I am hereby informed that the treatment methods are all generally safe, but there may be some side effects or risks. There are some risks to treatment, including bruising of the skin and/or slight bleeding, weakness, fainting and aggravation of symptoms existing prior to acupuncture treatment, allergies to metal in the needles. As with any invasive procedure there is a risk of puncturing organs (extremely rare). At the site of the needle insertion there may be soreness, numbness, tingling, or swelling. There is a small risk of infection at the needle site. Tempe Community Acupuncture (TCA) uses one-time use, sterile disposable needles. In no case is a needle ever reused.

I understand the acupuncturist may recommend herbal supplements. I understand I must stop taking any herbs and notify the clinic immediately if I experience adverse reactions. Any supplements recommended shall be obtained from a third party supplier. As such TCA is not responsible for the quality of ingredients in these formulas.

I will not walk around the clinic in bare feet, I will not leave my chair while needles are inserted, I will alert the staff if I see a needle on the floor but I will not touch it, I will not remove my own needles, I will not sit in a chair that does not have a white bucket placed upon the chair. I understand while in treatment I may signal for attention. I will do my required self check that all needles have been removed before leaving the treatment room. I understand TCA is not responsible for lost/stolen items.

If I am/have become pregnant, have a bleeding disorder, pacemaker, high blood pressure, local infection or have been prescribed anticoagulant medications. By signing below I state that I will inform my acupuncturist of such conditions.

I understand that I have the right to refuse any part of treatment. I do not expect my practitioner to be able to anticipate and explain all the possible complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during course of treatment, based upon the facts then known. I understand that no guarantee of cure or improvement in my condition is given or implied. I have read or have had read to me, this informed consent form. I have also had the opportunity to ask questions about its content, and by signing below, I agree to a course of treatment. I intend this consent form to cover my entire course of treatment for my present condition and for any future condition(s) I seek treatment for which I seek treatment with this practitioner. I understand that the treatment at TCA is not a replacement for medical care. I understand that TCA does not provide primary care.

With this knowledge, I voluntarily consent to the above procedures. I acknowledge that no guarantee has been given to results obtained.

Patient's Name

Date

Signature (Guardian Signature if minor)

Payment Policy

Payment is due at the time of service and may be paid by cash, check, Visa, Mastercard, or American Express. We do not file insurance claims of any kind and are not a Medicare/Medicaid provider. All sales are final, we do not offer refunds for services performed, unused gift certificates, etc. It is the patient’s responsibility to maintain record of daily payment amounts if needed. All promotional credits expire 6 months from date of purchase.

Cancellation Policy

Tempe Community Acupuncture works to make our service available to as many people as possible. With respect to this goal we ask for 4 hours advance notice if you need to cancel or reschedule. You may cancel by phone, using our online scheduling system, or by voicemail.

There is a \$15 cancellation fee for missed appointments that are cancelled/rescheduled with less than 4 hours notice. If there are any treatment credits on the account, 1 treatment credit will be deducted from the account in lieu of the cancellation fee.

Thank you for your understanding!

I affirm that I have read the payment and cancellation policies.

Privacy Policy

TCA takes the right to your privacy seriously. We do not disclose any personal, health, financial, or any other information about you, or the services we provide to you to any third parties without your request or permission. By signing, I understand that my email address/phone number may be used to receive notifications. I also understand that if I provide an email or phone number to Square credit card reader, they will text or email receipts from TCA purchases.

Patient’s Name

Date

Signature (Guardian if minor)