Citrus Community Acupuncture New Patient Intake

Name (Print) _____ DOB _____

Full Address _____

Phone # _____ Email _____

Have you had acupuncture before? _____ How did you hear about our clinic? _____

Please **fill in the blanks** and/or **circle** the underlined options that best apply to you.

PRIMARY complaint (list no more than two): _____/_____

I have had this complaint for _____ days / weeks / months / years. It comes and goes / is constant.

It is relieved with heat / cold / rest / movement / massage. It is worse with heat / cold / rest / movement / massage.

On the back of this form, please list medications, surgeries, and any diagnosed medical conditions.

- I tend to be too hot / cold. I experience hot flashes / night sweats / excessive sweating / inability to get or stay warm.
- I sleep well / poorly. I have trouble falling / staying asleep. I am often / rarely fatigued.
- I rarely / often have congestion. I have coughing / runny nose / phlegm in my chest or throat / shortness of breath.
- I have dry eyes / dry skin / a diagnosed skin condition: _____
- My digestion is good / poor. I often have nausea / vomiting / acid reflux / bloating / diarrhea / constipation.
- I am often / rarely in pain. The pain is constant / comes and goes. Pain location: _____
- I have high / moderate / low stress. I often / rarely get time to do things I enjoy.
- I often / rarely have headaches. The headache is located: top / back / sides / temples / sinuses / forehead.
- A Medical Doctor diagnosed me with high blood pressure / hypothyroid / hyperthyroid / diabetes / apnea / asthma.
- I smoke _____ packs of cigarettes per day. I have _____ alcoholic beverages per week.

Please answer the following questions only if they apply to you.

- I have no / minor / severe symptoms of PMS: w/ cramping / mood swings / irregular cycle / clots / abnormal bleeding
- I am not pregnant / pregnant. Current day in cycle _____ Average number of days in cycle _____.
- I am menopausal / post-menopausal. I am taking no / natural / synthetic hormones.
- I experience impotence / premature ejaculation.

Informed Consent and Financial Policy

- I hereby request and consent to the performance of acupuncture or other modalities within the scope of practice of Oriental Medicine on me by David Bibbey, L.Ac., who is licensed by the state of Florida to practice acupuncture.
- I understand that there are some risks to treatment, including but not limited to some bruising and/or slight bleeding, some pain at the insertion sight of the needle, dizziness or fainting, or possible aggravation of pre-existing symptoms. The risk infection is very low and all needles used at Citrus Community Acupuncture are sterilized by manufacturer when packaged, single-use only, and disposable.
- I have had the opportunity to discuss my acupuncture treatment plan with David Bibbey, L.Ac. I understand that results are not guaranteed. I do not expect David Bibbey, L.Ac, to be able to anticipate and explain all outcomes and risks. I understand that I may stop treatments at any time. I understand that the health evaluation provided to me is an energetic assessment based on the theories of Oriental Medicine. I understand that David Bibbey, L.Ac, is not providing Western (allopathic) medical care, and that I should consult my primary care medical doctor for those services and other routine check-ups.
- The cost of community acupuncture treatments is payable on a sliding scale of $15.00-$35.00, plus a one-time fee of $10.00 due at the first visit. Payment is expected at the time of treatment.
- Unless canceled at least 12 hours in advance, our policy is to charge $15.00 for missed appointments.
- I have read the above consent and financial policy. I have had the opportunity to ask questions, and by signing I consent to receiving acupuncture treatments provided by David Bibbey, L.Ac, or an authorized representative of Citrus Community Acupuncture. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature _____ Date _____

Emergency Contact Name and Phone _____