RED RIVER ACUPUNCTURE

New Patient Form

Name: _____ Date of Birth: _____

Address: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact (name and phone #): _____

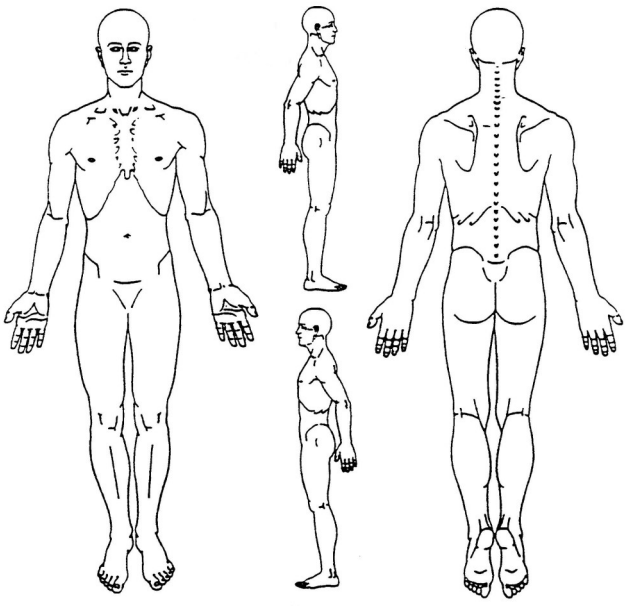
Have you been treated by acupuncture or Traditional Chinese Medicine before? Y □ N □

Are you currently under the care of other health care providers? Y □ N □

If yes, please list: _____

Main Health Concerns	**Details of Concern (when did it begin, what is it associated with, what makes it better or worse)**

Please indicate areas of pain or discomfort on image below:



Medications or Supplements Please note any drugs, hormones, supplements you take regularly	
Injuries, Traumas or Surgeries Please note what, where and when	

Do you follow a special diet?

Y □ N □ Type?

Do you exercise regularly?

Y □ N □ Type?

Habits	**Amount**	**Quit**
Sugar		□
Caffeine		□
Tobacco		□
Other		□

Please check the box if you experience or have experienced any of the following conditions:

□ Allergies	□ Asthma	□ Addiction	□ Kidney disease
□ Arthritis	□ Osteoporosis	□ Lung disease	□ HIV/AIDS
□ Pneumonia or bronchitis	□ High/low blood pressure	□ Skin problems	□ Anemia
□ Prostatitis	□ Cancer	□ Mental illness	□ Heart disease
□ Thyroid disease	□ Neurological conditions	□ Addiction	□ Fibromyalgia
□ Seizures	□ Liver disease	□ High cholesterol	□ Diabetes
□ Stroke	□ Gallbladder disease	□ Sexually Transmitted Inf.	□ IBS/chrones/colitis

Please check the box if you have experienced any of the following symptoms in the past MONTH:

□ pain/weakness of lower back	□ muscle pain or tension	□ insomnia	□ abdominal pain	□ shortness of breath
□ pain/weakness of knees	□ tremors or poor motor control	□ heart palpitations	□ bloating	□ difficulty breathing
□ frequent urination	□ muscle cramps	□ dream disturbed sleep	□ gastrointestinal colic or gas	□ cough
□ incontinence	□ numbness or tingling	□ anxiety	□ diarrhea	□ pain with breathing
□ night sweats	□ dizziness	□ restless sleep	□ constipation	□ spontaneous sweating
□ low libido	□ headache	□ panic attacks	□ foul smelling stools	□ lack of sweating
□ impotence	□ vision changes	□ lack of joy	□ excessive appetite	□ frequent cold or flu
□ infertility	□ dry, red or watery eyes		□ poor appetite	□ skin problems
□ edema	□ irregular menstrual periods		□ joint pain or swelling	□ grief
□ painful or burning urination	□ painful menstrual periods		□ nausea	
□ ringing in ears	□ PMS		□ acid reflux	
□ excessive fear	□ mood swings		□ fatigue	
	□ irritability or excessive anger		□ muscle weakness	
			□ memory loss	
			□ over thinking	
			□ excessive worry	

What do you do to support your well-being? _____

What is your main goal of treatment? _____

RED RIVER ACUPUNCTURE

Consent to Treatment

I, _____, hereby consent to acupuncture and/or other techniques used in the practice of Traditional Chinese Medicine provided to me for the relief of presenting symptoms, improved health and well-being, reduced stress and general relaxation.

Side Effects: While acupuncture is a very safe natural method of treatment, certain side effects may result. These could include, but are not limited to, local bleeding and/or bruising, temporary pain or discomfort, numbness or tingling near the needle site that may last a few days, dizziness or fainting, temporary aggravation of symptoms, and in very rare cases internal organ perforation. Good communication is key to receiving a treatment that keeps you safe and is within your comfort zone. Please let the practitioner know if you are uncomfortable.

Responsibility: Acupuncture is a valuable complement to Western medicine, but, is not a substitute for it. While we can provide care for many health issues, you should visit your primary care physician for regular check-ups or the hospital for emergencies and potentially serious health conditions.

Pregnancy: Acupuncture can be very beneficial in improving fertility, treating any symptoms during pregnancy, and assisting in the birthing process and postpartum care. Please notify the acupuncturist if you are trying to conceive or have become pregnant so they can make necessary adjustments to your treatment plan.

Privacy: Sharing important details of your health history is helpful in determining the best treatment plan for you. Personal records will be viewed and discussed by acupuncturists at Red River Acupuncture, but, will otherwise be kept confidential. No information will be released without consent. Please notify the acupuncturist if there are certain topics that need extra discretion.

Cancellation policy: Since scheduling an appointment involves the reservation of time specifically for you, we ask that you notify us if you need to cancel or reschedule an appointment. You may cancel your appointments online up to 24 hours prior to treatment. After that please call the clinic. Sessions missed without advance notification will result in a cancellation fee equal to the cost of treatment.

I have carefully read and understand all of the above.

Signature: _____ Date: _____