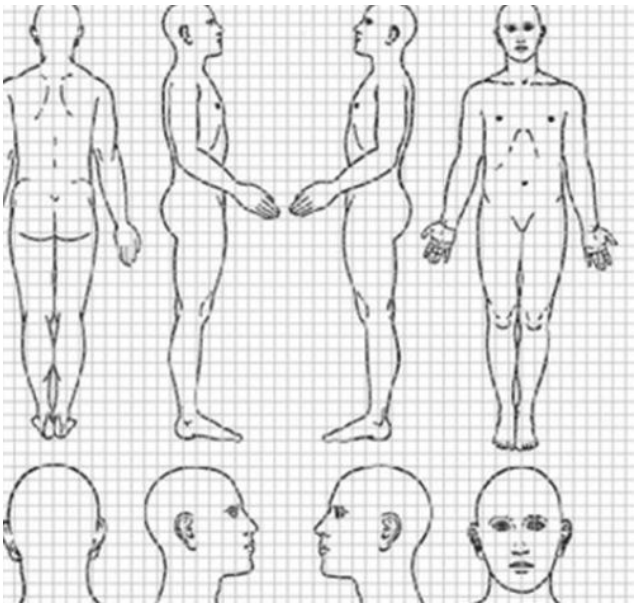
Community Acupuncture of Orlando
New Patient Intake Form

NAME _____ DATE OF BIRTH _____

EMAIL _____ PHONE # _____ ZIP CODE _____

Have you had acupuncture before? YES / NO How did you hear about us? _____

What is your PRIMARY health concern?_____
When did this start?_____ Is it constant? YES / NO Better with HEAT / COLD



Indicate pain/areas of concern above

Please check what applies to you:

__Stressed/ overwhelmed
__Difficulty Sleeping
__Anxiety/ nervousness
__Irritability/ anger
__Night Sweating
__Edema/ Swelling
__Skin Problem
__Easily Bruised
__Sinus Problem
__Easily Catches a Cold
__Heart Disease
__Breathing Problem
__High/ Low Blood Pressure
__Circulation Problem
__Urinary Problem
__Irregular/Painful Periods
__ Kidney Problem/ Stone
__Gall Bladder Problem/ Stone

__Depressed
__Fatigue
__Hot Flashes
__Headaches
__Migraines
__TMJ
__Eye Problem
__Ear Problem
__Fainting
__Fibroids
__Dizziness
__Coughing
__Palpitations
__Indigestion
__Diarrhea
__Constipated
__Prostate
__Breast lumps

Please list medication, surgeries, diagnosed medical conditions, and anything else you would like us to know on the back.

Informed Consent and Financial Policy

I hereby consent to the performance of acupuncture or other modalities within the scope of practice of the Florida state licensed acupuncturists of Community Acupuncture of Orlando. I understand that there are some risks to treatment including but not limited to bruising and/or bleeding, pain at the site of needle insertion, dizziness or fainting, and possible aggravation of symptoms existing prior to treatment. The risk of infection is very slight as all needles used are pre-sterilized, single-use, and disposable. I understand the zero gravity chairs will hold no more than 220 lbs. I have had the opportunity to discuss with my acupuncturist the nature and purpose of acupuncture. I understand that results are not guaranteed. I do not expect my acupuncturist to be able to anticipate and explain all outcomes and risks. I understand that I may stop treatment at any time. I understand that the evaluation given to me is an energetic assessment based on the theories of Traditional Chinesse Medicine. I understand that my acupuncturist is not providing Western (allopathic) medical care and that I should look to my primary care practitioner for those services and routine check-ups. Payment is expected at the time of treatment. The cost of an acupuncture treatment and cupping is payable on a sliding scale. I have read the above consent and financial policy. I have had the opportunity to ask questions, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Signature _____ Date _____