CORE**ACUPUNCTURE**
health + wellness

NEW PATIENT INFORMATION

(PLEASE PRINT)

Today's Date:	Last Name:		First Name:	
Date of Birth: / /	Age:	Male / Female / Non-binary	Preferred Name:	
Street Address:		City:	State:	Zip:
Preferred ph. (cell / wk / hm): ( ) -		email:		
Alt. phone (cell / wk / hm): ( ) -		Occupation:		
Who do you live with? no one / roommate / spouse / other: ________________________________				
Are you: Single / Married / Divorced / Widowed				

Insurance Information

Do you have insurance that covers Acupuncture?	Yes / No / Not sure
Insurance Company:	

In Case of Emergency

Name:	Your relationship to this person:
Cell / wk / home phone: ( ) -	Cell / wk / home phone: ( ) -

How did you hear about us? ***Please circle one***

Friend / Family / Practitioner / Facebook / ATC / Georgia Sports Chiropractic

Internet Search / Morningside / IG / Nextdoor / Other ________________________________

Acupuncture Informed Consent to Treat

I hereby request and consent to the performance of Acupuncture treatments and other procedures within the scope of the practice of Acupuncture on me (or the patient named below, for when I am legally responsible) by the Acupuncturist indicated below and/or other licensed Acupuncturist(s) who now or in the future treat me while employed by, working or associated with or serving as back-up for the Acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, Acupuncture, Moxibustion, Cupping, electrical stimulation, Tui-Na (chinese massage), Chinese Herbal Medicine and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instruction provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff or any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that Acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness, or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scaring are a potential risk of moxibustion and cupping, or when treatments involves the use of heat lamps. Marks that look similar to bruising is a common side effect of cupping. Unusual risks of Acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic only used sterile disposable needles and maintain a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe run the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all the possible risks and complications of treatments, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of Acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Acupuncturist Name: Jennifer Myers, Dipl.Ac. L.Ac.

Patient Signature **X** ____ Date: ________________

(or patient representative, indicate relationship if signing for patient)