ACUPUNCTURE OFF BROAD

267-581-2791
INFO@ACUPUNCTUREOFFBROAD.COM
1315 FEDERAL STREET
PHILADELPHIA PA 19147

Please complete this form as thoroughly as possible; all answers are confidential.

GENERAL INFORMATION

Name _____

Today's Date _____ Date of Birth _____

Address _____

_____

City _____ State _____ ZIP code _____

Email Address _____

Phone Number _____

Occupation _____

Single ☐ Married ☐ Partnered ☐ Widowed ☐ Seperated/Divorced ☐

Emergency Contact Name _____

Relation _____

Emergency Contact Phone Number _____

How did you hear about us? _____

GOALS What health concerns would you like to address through treatment?

_____

_____

_____

To help us maintain a peaceful space for people to relax, please silence your cell phone and speak quietly in the clinic and waiting area.

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FAMILY HISTORY Please complete for each family member as best you can.
Place a ✔ or the date in the appropriate box or boxes.

	self (date)	mother	father	sibling	spouse/partner	children
Adopted						
Good health						
Alcohol or drug use						
Depression/anxiety/trauma						
Allergies						
High blood pressure/heart disease/stroke						
Cancer or tumors						
Diabetes						
Seizures						
Hepatitis/other liver disorder						
Musculo-skeltal disorder						
HIV/AIDS						
Blood or bleeding disorders/anemia						
Thyroid disorders						
Kidney disorders						
Deceased (age)	N/A					

MEDICAL If you have ever been hospitalized or in the emergency room for a serious condition, please list them below.

Illness	Year

MEDICATIONS & SUPPLIMENTS Please list all mediactions, vitamins and/or suppliments you are currently taking.

Medication/Suppliment	Reason

ADDITIONAL QUESTIONS

Are you pregnant? _____
Do you have a pacemaker? _____
Do you have a history of fainting? _____
Is there anything else we should know? _____

☐ Check here if you are seeking treatment for injuries sustained in a motor vehicle accident.

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CONSENT

Your treatment may include one or more of the following practices:
Acupuncture, Gua Shua, Moxibustion, Tui Na, Herbal Medicine, Diet Therapy, Oils and Liniments.

Purpose of Treatment: The purpose of treatment is to provide a health care service that is based on a traditional Chinese system of medical theory. Diagnosis and treatment based on these theories are used to promote health and to treat organic and functional disorders. TCM is not a replacement for conventional medical care.

Benefits of Treatment: Relief of presenting symptoms, improved circulation, optimizing the body's ability to heal itself, and wellness. These benefits may lead to prevention or elimination of the presenting problem, and strengthening of the patient's constitution. Of course, the practitioner cannot guarantee the outcome of any course of treatment.

Risks of Treatment: Traditional Chinese medical practices have been shown to be relatively safe. However, there are some uncommon but potential risks. These potential risks may include:

1. Discomfort during the insertion of a needle.
2. Dizziness or fainting.
3. Minor bruising or temporary discoloration of the skin.
4. Minor burns with the usage of some types of moxa.
5. Possible temporary aggravation of symptoms that existed prior to treatment.
6. A broken needle **(very rare with the use of disposable needles).**
7. Infection (very rare with the use of disposable needles).
8. Gastro-intestinal upset with the use of Chinese herbs. **(If this should occur, please notify your practitioner).**

Special Situations: Some herbs and acupuncture points are contraindicative under certain situations. Please notify your practitioner **PRIOR TO TREATMENT** if you are **PREGNANT**, if you have **SEVERE BLEEDING DISORDERS**, or if you are wearing a **PACEMAKER** or **OTHER ELECTRONIC MEDICAL DEVICES**.

Cancellation Policy: Our clinic requires a **24-HOUR NOTICE OF CANCELLATION**. In respect for our intention to offer high quality health care at affordable rates, and for others in the community in need of treatment at specific times, we have a strict cancellation policy. All appointments that are rescheduled/cancelled with less than 24-hour notice will be charged a **thirty dollar ($30) cancellation fee.** Appointments that are missed without notice will be charged the regular fee for that appointment.

I, _____ request and consent to receiving acupuncture and other traditional Chinese medical practices. I understand that I am free to withdraw my consent and that I may stop treatment at any time. I understand that my signature on this form indicates that I have read and comprehend the preceding information regarding my treatment. I understand that if I have any questions about this information, I should ask the treating practitioner.

I, _____ understand that there is a 24-hour cancellation policy and that if I do not adhere to the policy, I will be responsible for paying the fee.

I, _____ release Acupuncture Off Broad and its practitioners from any and all liability that may occur in connection with the above-mentioned procedures.

Patient's Name (Please Print): _____

Patient's Signature: _____ Date Signed: _____