Annapolis Community Acupuncture, LLC
Patient Registration and Health History Form

Name ________________________________ "Nickname"_______________ ☐Veteran ☐Active Duty
Address __________________________________ City _______________ State _____ Zip _________
Email: ____ Phone: _______- _______-_________
Date of Birth _____/_____/_____ Gender Identity: _______________ Occupation: ________________
Emergency Contact Name: ___________________________________ Phone: ______-______-________
Who told you about us? ____________________________________ ☐ I have had acupuncture before

The more we know about you, the better we can provide high quality acupuncture designed specifically for your needs. Thank you for completing the information on this form!

***Will copies of your medical records need to be released to another party? Yes / No**

Problem 1) _______________________ Started: ______ Other Treatments: ______________________
Right Now: (10 = severe): ______/10. Describe: ____
How bad can it get? (10 = severe): ______/10. Describe: ______________________________________
I have it ________ hours / day. It interferes with: ____
Gets worse from: __________________________ Gets better from: ____________________________
Problem 2) _______________________ Started: ______ Other Treatments: ______________________
Right Now: (10 = severe): ______/10. Describe: ____
How bad can it get? (10 = severe): ______/10. Describe: ______________________________________
I have it ________ hours / day. It interferes with: ____
Gets worse from: __________________________ Gets better from: ____________________________
Problem 3) _______________________ Started: ______ Other Treatments: ______________________
Right Now: (10 = severe): ______/10. Describe: ____
How bad can it get? (10 = severe): ______/10. Describe: ______________________________________
I have it ________ hours / day. It interferes with: ____
Gets worse from: __________________________ Gets better from: ____________________________

Medical Information & *Ebola screening*: ☐Been to West Africa in last 30 days?
☐Exposed to anyone from there who is sick? ☐Flu symptoms? ☐Fever? ☐ Unexplained Bleeding?
☐Latex Allergy ☐Silicone Allergy ☐Implanted Medical Devices:___________________________
☐Seizures: ___________________________________ Doctor (for seizures): _____________________
☐Cancer/Tumor: _________________________________ Doctor (for cancer): ______________________
☐Restrictions on needling arms/legs ☐Lymphedema ☐Fatigue ☐ER/Hospital Visit: ________________
☐Sleep Apnea/CPAP ☐Insomnia ☐Anxiety ☐ADD ☐ADHD ☐Depression ☐Bi-Polar ☐OCD ☐PTSD
☐Diabetes ☐Hypoglycemia ☐Thyroid ☐High Blood Pressure ☐Hepatitis A/B/C ☐HIV/AIDS
Chronic Pain(s): ________________________ ☐Muscle tightness ☐Cramps/Spasms ☐Restless Legs
Concerned about: ☐Alcohol use ☐Medicine use ☐Smoking ☐Caffeine use ☐Cravings: ____________

Please check all that apply to you in the last 30 days:
☐Pregnant: due: ______ ☐Trying to get pregnant ☐NOT Pregnant ☐PMS ☐Menstrual ☐Menopausal
☐Stress ☐Low Energy Level ☐Trouble falling asleep ☐Wake up often ☐Disturbing Dreams
☐Sad ☐Worried ☐Grieving ☐Fearful ☐Irritable ☐Overwhelmed ☐Trouble focusing/concentrating
☐GERD/Reflux ☐Nausea ☐Vomiting ☐Bloating ☐Gas ☐Constipation ☐Diarrhea ☐Urine problems
☐Often sick ☐Weak voice ☐Sore throat ☐Lump in throat ☐Short of Breath ☐Chest tight ☐Wheezing
☐Palpitations ☐Chest pain ☐Weakness ☐Fainting ☐Dizziness ☐Night Sweats ☐Hot Flashes
☐Allergies ☐Sinus congestion ☐Itching ☐Rash ☐Numbness ☐Tingling ☐Burning
☐Medicines:____

*****PLEASE WRITE YOUR NAME AND SIGN IN THE HIGHLIGHTED PORTIONS ON PAGE 2 >***

WE CANNOT ACCEPT THESE FORMS ELECTRONICALLY. DO NOT EMAIL!

Annapolis Community Acupuncture, LLC
Acupuncture Information and Informed Consent for Treatment

I, ___________________________________, voluntarily consent to acupuncture services provided by Annapolis Community Acupuncture, LLC. Acupuncture involves the insertion of sterile, single-use, disposable needles through the skin in specific locations. I may also be treated with heat applied to the skin. While side effects are rare, they may include local bruising, slight bleeding, temporary pain or discomfort, fainting, infection, burns, broken needles, pneumothorax (collapsed lung) and spontaneous miscarriage. **About 15% of people experience a temporary worsening of their condition or a flare-up of old conditions following their first few treatments. This is known as a "healing reaction" and it is a normal part of getting better.** Infectious diseases are carried through the air, through physical contact, and through body fluids. I understand that my acupuncturist follows universally prescribed precautions and procedures to prevent the spread of infectious disease.

I understand that each person is unique and each has ultimate responsibility for his/her own healthcare. **I agree to inform my acupuncturist about my medical conditions, medications, and any changes that occur during the course of treatment (including pregnancy and suspected pregnancy). I agree to contact my acupuncturist immediately if I experience any problem which I associate with the acupuncture services provided.** If I experience a medical emergency, a worsening of my health condition, or a new condition arises, I will consult a licensed physician, or seek medical treatment.

I understand that my practitioner is a Licensed Acupuncturist in Maryland, not a licensed physician, and does not provide primary medical care. My acupuncturist will not suggest that I discontinue medical treatment, and may request that I have a consultation with and/or physical examination by a licensed physician.

I have had the opportunity to ask my acupuncturist questions regarding the proposed acupuncture services, this consent form, and other pertinent information, including any questions about my practitioner's education and experience, and I have received a satisfactory explanation.

I understand the acupuncture services provided at Annapolis Community Acupuncture, LLC, and the fees. Annapolis Community Acupuncture, LLC does not bill insurance or complete any insurance forms. Upon request, they will provide me with a receipt which I can submit to my insurance. Please be aware that we cannot guarantee that your insurance will reimburse you for our services. It is your responsibility to research your insurance coverage.

Community Acupuncture Services are treatments designed specifically for my needs provided in a group setting. The fee is a sliding scale of $15.00 to $40.00 per treatment, plus a one-time additional fee of $10.00 for the initial evaluation. **I decide what I can afford, and no income verification is performed. I understand that what I pay never affects the care I receive**. Appointments strongly recommended. I understand that all appointments that are cancelled with less than 24 hours advance notice and appointments missed without notice will be charged the cancellation fee of $15.00.

I understand that when I select Community Acupuncture provided in a group setting, conversations in the group room may be overheard. If I wish to discuss a sensitive issue or a detailed discussion about my medical history, we may need to schedule this separately by phone.

I understand that Annapolis Community Acupuncture, LLC will not contact my physician without my written consent. I give my consent to inform my physician ____________________________ that I am receiving acupuncture.

I understand that Annapolis Community Acupuncture, LLC will record medical & other information about my treatment, and that my health information will be used & disclosed consistent with the Notice of Privacy Practices. I permit a copy of this authorization to be used in place of the original. This authorization does not allow the release of my treatment records, which require a restricted release under State or Federal Law.

I have read and understand all the information on this form. I acknowledge that I have not received any guarantees or promises of results from these services, and I understand that I am free to discontinue services at any time.

I have received a copy of the Notice of Privacy Practices (attached to the Patient Registration / Health History form). I am aware that this form is also in the waiting room &may be accessed in the FAQ section on the clinic's website.

*Patient's Printed Name ____

*Patient's Signature ____ Date ________________

The undersigned represents that he or she is the parent or legal guardian of the minor named above, and represents that he or she has the legal authority to sign this consent and authorize acupuncture treatment.

*Parent's Signature ____ Date ________________

*Witness Signature____ Date ________________

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