Dr Elizabeth Stephenson, AP
Acupuncture Physician

Patient Intake Form

*Name*______________________________________*Date*_______________________

*Address*____

*Phone(home)*___________________________*(cell)*______________________________

May we leave a message? ______*Yes* *or* _____ *No*

*Date of Birth*__________*Emergency Contact*________________________________

*Phone*_______________________________________

Health Concerns

____
____
____
____
____
____

Please list any medications and supplements you are currently taking, along with doses and the reason you are taking them:

Medications:	Purpose:	Date began:	Dose:	Effects? + or -

Supplements:	Purpose:	Date began:	Dose:	Effects? + or -

Please describe any pain sensations in your own words

____

____

____

____

____

____

____

Rate your pain on a scale of 1- 10**____**

Please check if any of the following apply to you:

□Hemophilia □Epilepsy □Vegetarian □Pacemaker □Diabetes □High Blood Pressure
□Take aspirin or blood thinners □Cancer □HIV □ HepB □Might be pregnant
□Smoke-How often?________ □Drink Alcohol-How much?_____________ □Sedentary Lifestyle

Informed Consent to Acupuncture Service:

I understand that there are minor risks associated with acupuncture treatment, including, but not limited to, slight bleeding and/or bruising of the skin. I understand that the risk of infection is negligible when using single use, disposable needles.

I have had the opportunity to discuss with the acupuncturist the nature and purpose of acupuncture. I understand that results are not guaranteed.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications. I wish to rely on the acupuncturist to exercise good judgment during the course of the procedure, based on the facts then know, and act in my best interest.

I have read the above consent, or have had it read to me. I have had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend for this consent form to cover the entire course of treatment for my present condition, as well as any future conditions for which I may seek treatment.

Patient Signature

____*Date*______________________