

Patient Information

Name (Last, First, Middle) _____

Phone _____

Age _____ DOB _____ Sex _____ Marital Status _____

Address _____

E-Mail _____

Spouse Name _____

Phone _____

Contact in case of an emergency	Relationship	Phone
_____	_____	_____

Work Information

Occupation _____ Business Phone _____

Employer's Name _____

Employer's Address _____

How do you know the clinic?

Whom should I thank for the referral? Name _____

Phone _____

Consent & Signature

1. Acupuncture could cause the following: Fainting, stuck needle, bleeding, bruising, pain, soreness, numbness, heaviness, itchiness and crawling sensation.

2. Auricular therapy could cause the following: Pain, bleeding, allergic reaction to auricular seed type.

3. Cupping could cause the following: Bruising, allergic reaction, itching, ring marks, blistering of skin.

If you consent to any of the above treatment methods, please sign your name and email to Sarah, or bring to the clinic at your first appointment.

Patient Signature _____ Date _____

Pain Managment

Weight Contol

Menopause