Yogapuncture Intake Form

Name: _____ Date: _____ DOB: _____

I have had acupuncture before: ☐yes ☐no

Today is a ☐typical or ☐atypical day, please explain: _____

My energy level is generally (check all that apply):

☐high ☐average ☐low ☐non-existent ☐fluctuates

My sleep is generally (check all that apply):

☐restorative ☐poor ☐restless ☐dream-filled ☐disrupted by children/pets/snoring

Emotionally I am feeling (check all that apply):

☐happy ☐@peace ☐sad ☐angry ☐anxious ☐worried ☐fearful ☐depressed

I have allergies to (check all that apply):

☐the environment ☐food ☐the seasons ☐pets ☐other: _____

I am in pain:

☐constantly ☐frequently ☐intermittently ☐occasionally ☐almost never
Explain: _____

I have been diagnosed with the following conditions/am currently being treated for:

_____

_____

_____

_____

Ladies only: I am currently pregnant: ☐yes ☐no I currently have my MP: ☐yes ☐no
My last MP began: _____ Menopause began: _____

Is there anything else you think I should know or that you feel needs to be discussed

privately before the start of class? ☐No ☐Yes: _____

_____

_____

_____

_____ OVER--->

Informed Consent to Acupuncture Treatment:
(Yogapuncture/acupuncture at West End Yoga)

I consent to acupuncture treatments provided by a Licensed Acupuncturist of LiveWell Integrated Health LLC during class at West End Yoga. I understand that this treatment will be performed in a group setting, and as such anything discussed will be discussed as a group. I will notify my treatment provider if I questions or concerns that need to be discussed privately prior to the start of class.

Purpose of Treatment: The purpose of treatment is to provide a health care service 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 medicine.

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. The practitioner cannot guarantee the outcome of any course of treatment.

Risks of Treatment: Acupuncture has 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. Numbness or tingling near the insertion sites.
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. Very rare and unusual risks include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax).

I will notify the clinical staff member who is caring for me if I am, or become pregnant. I understand that members of the clinical staff of LiveWell Integrated Health LLC may discuss my case to provide thorough and accurate treatment of my condition. Otherwise all of my records will be kept confidential and will not be released to any party without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture, 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.

To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated).

_____
Date Consent Completed

_____
Print Name of Patient (or patient representative)

_____
Signature of Patient (or patient representative)

To be completed by the member of the Clinical Staff providing information and obtaining consent.

_____
Print Name of Clinical Staff

_____
Signature of Clinical Staff