North Shore Community Acupuncture

Date: ____ /____ /____

Name (First, Last): _____ DOB: ____/____/____ Age: _____

Address: _____ City/State: _____ Zip Code: _____

Phone: _____ Cell: _____ Email: _____

Occupation: _____ Referred by: _____

What is the main issue(s) that you would like to address with acupuncture? _____

_____

How long has this been an issue? _____

What makes it better? _____ What makes it worse? _____

Does this issue interfere with your ability to work? **Y / N** Does it interfere with your ability to rest? **Y / N**

Please list any injuries or surgeries: _____

Energy – do you have enough energy to get through the day? **Y / N / Sometimes**

Stress Level (scale 1 – 10): _____ Main Cause of stress: _____

Sleep – on average how much sleep do you get? Enough Not enough Hardly any Too much
Do you have a hard time falling asleep? **Y / N** Staying asleep? **Y / N** Do you feel rested after sleeping? **Y / N**
Hours of sleep per night: _____

Digestion (circle all that apply):
Poor appetite Excessive hunger Gas Bloating Heartburn Acid reflux Nausea Diarrhea Constipation
Bowel movements: _____ time(s) every _____ day(s).

Men's Health (circle all that apply): Erectile dysfunction Prostate problems Testicular pain or swelling Low libido

Women's Health: Date of last period (if post-menopause, just the year): _____ Length of period: _____
Length of cycle: _____ Are cycles regular? **Y / N** Are you pregnant? **Y / N** Are you trying to get pregnant? **Y / N**

If so, for how long? _____ Total # of pregnancies: _____ Total # of live births:_____

Do you experience: Yeast infections Vaginal dryness Chronic UTI Low libido Spotting Clots Heavy / Light flow
PMS Cramps Breast tenderness Mood swings Sadness Bloating Hot flashes Night sweats

Circle all that apply:

Depression Dizziness or Vertigo Hormonal changes Diabetes Anxiety Irritability Excessive fear Thyroid issues
Cancer Frequent colds Allergies Asthma Auto-immune disorder Headaches or Migraines TMJ High or Low Blood pressure Hard to focus Poor memory Tinnitus Poor circulation Cold hands/feet HIV Hepatitis C

List any medications (include supplements): _____

Any allergies? **Y / N** If so, please list them: _____

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ACUPUNCTURE INFORMED CONSENT TO TREAT

Please read and sign below.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter).I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

North Shore Community Acupuncture

Cancellation and No-Show Policy

It is required that all cancellations occur at least 24-hours prior to your scheduled appointment time. Missed appointments can interfere with your progress in treatment. Also, when an appointment is missed without canceling within a 24-hour period, we do not have the opportunity to offer that time to someone else in need of services.

To ensure that North Shore Community Acupuncture best meets the needs of all, it is our policy that patients are responsible for all appointments they have scheduled. If you do not cancel prior to 24-hours of your appointment or you do not show up for your appointment there will be a fee of $35. Extenuating circumstances and special situations will be reviewed on an individual basis per the discretion of North Shore Community Acupuncture, LLC.

Consent for Purposes of Treatment, Payment and Health Care Operation

I understand that North Shore Community Acupuncture, LLC will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that payment is due at the time of service.

I hereby give my consent for the use of email, voice and/or text messaging to communicate about my care at North Shore Community Acupuncture, LLC including pending appointments. I understand that such communications may include personal healthcare information and that such transmissions are not encrypted. Such communications are limited to me and parties with whom I give written permission to communicate. At no time will such contact information be shared or publicized. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I have read the policies and understand the risks involved and agree to fully cooperate, participate in all procedures, and comply with the established plan of care. I do hereby agree and give my consent for North Shore Community Acupuncture, LLC to furnish care and treatment that is considered necessary and proper in diagnosing and treating of my physical condition.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, cancellation and no-show policy and Consent for Purposes of Treatment, Payment and Health Care Operation and have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. 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.

PATIENT NAME:

PATIENT SIGNATURE X DATE:

(Or patient representative. Indicate relationship if signing for patient.)

ACUPUNCTURIST NAME: _____

North Shore Community Acupuncture

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources.

I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (*please initial in all seven places provided*)

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____ **(initials)**
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____ **(initials)**
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____ **(initials)**
- I confirm that I will cancel my appointment and not enter North Shore Community Acupuncture if I am experiencing any of the following symptoms of COVID-19 that are listed below: _____ **(initials)**

  *Fever *Shortness of Breath *Dry Cough *Runny Nose *Sore Throat *Loss of Taste or Smell
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____ **(initials)**
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____ **(initials)**
- I have been offered a copy of this consent form. _____ **(initials)**

I knowingly and willingly consent to the treatment with the full understanding and disclosure of the risks associated with receiving care during the COVID-19 pandemic. I confirm all my questions were answered to my satisfaction.

I have read, or have had read to me, the above COVID-19 risk informed consent to treat. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers at North Shore Community Acupuncture, LLC for my present condition and for any future condition(s) for which I seek care from this office.

PATIENT NAME: _____

PATIENT SIGNATURE X _____ (Date) _____

(Or patient representative. Indicate relationship if signing for patient)