PRINT, COMPLETE AND BRING
TO YOUR INITIAL APPOINTMENT.

Maine Center for Acupuncture
Consent to Services

Patient Name: _____

Today's Date: _____/_____/_____ Date of Birth: _____/_____/_____

Phone Number(s): _____

Mailing Address: _____
(street address)

_____
(town/ city) (state) (zip code)

E-mail: _____

I HEARBY VOLUNTARILY CONSENT TO ACUPUNCTURE TREATMENT.

☐ I understand that acupuncture serves individuals with a wide range of complaints including both acute and chronic healthcare issues. I understand that I may be treated with one or more of the following: the insertion of needles and Zero Balancing.

☐ I understand that acupuncture and the other techniques listed above may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain, and discomfort, temporary discoloration of the skin and temporary aggravation of symptoms existing prior to treatment.

☐ I know that each person is ultimate responsibility for his/her own healthcare. I acknowledge that I have not received any guarantees or promises as to the results or success that will be obtained from the services provided.

☐ I understand that infectious diseases are carried through the air, through physical contact, and through body fluids. Maine Center for Acupuncture practitioners follow universally prescribed precautions and procedures (such as clean needle technique and hand washing) to prevent the spread of infectious disease.

☐ I understand that it is my responsibility as a patient to inform my practitioner about all aspects of my health and that, as service progresses, to inform my practitioner of changes that occur. If I experience any pain, discomfort, or possible adverse side effects, it is my responsibility to immediately notify my practitioner.

☐ I recognize that an acupuncturist is not a substitute for a medical doctor and will not suggest that I discontinue medical treatment. I am free to consult a medical doctor or any other licensed practitioner at any time. I understand also that if there is an emergency, or a worsening of my health condition, or if a new ailment or condition arises, that I should consult a licensed physician.

☐ I have been informed of the fees for service, and I understand that payment is due at the time of treatment.

☐ **If I cancel an appointment with less then 24 hours notice, then I must pay a $30.00 late cancelation fee for a "Follow up Acupuncture" appointment or $50.00 for an "Acu + 10" appointment.**

_____ (initial and date that you understand and accept the payment and cancelation policy)

☐ I have read and understand all of the above and acknowledge that the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of acupuncture treatment have been explained to me. I have felt free to ask my practitioner questions regarding the proposed services and other pertinent information, including questions about him, and have received satisfactory explanations. I understand that I am free to discontinue treatment/services at any time.

Patient Signature (if under age 18 must be signed by legal guardian)

_____

PRINT, COMPLETE AND BRING
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Maine Center for Acupuncture
Patient Health Profile

Patient Name: _____

Today's Date: _____/_____/_____ Date of Birth: _____/_____/_____

I have had acupuncture before: (circle) YES NO

My occupation & employer: _____

My emergency contact is:

_____

(name) (relationship) (phone number)

My Primary Care Physician:

_____

(name) (phone number) (city/town, state)

I give permission for Maine Center for Acupuncture to contact my doctor: (circle) YES NO

I am presently under a doctor's care for the following conditions: _____

_____

I need a receipt for health insurance reimbursement: (circle) YES NO

I learned about Maine Center for Acupuncture from:

MCA Patient: _____

Other (please state): _____ ☐ I like MCA on Facebook

TOP THREE CONCERNS

1. _____

When did it start: _____

What makes it better: _____

2. _____

When did it start: _____

What makes it better: _____

3. _____

When did it start: _____

What makes it better: _____

MY HEALTH HISTORY

Check any conditions you have or previously had and **list when** symptoms began.

- ☐ AIDS/ HIV _____
- ☐ Alcoholism _____
- ☐ Allergies _____
- ☐ Anemia _____
- ☐ Asthma _____
- ☐ Arthritis _____
- ☐ Autoimmune disorder _____
- ☐ Back Pain _____
- ☐ Cancer _____

List type:

- ☐ Depression _____

Other mental health issue:

- ☐ Diabetes _____
- ☐ Digestive issues _____
- ☐ Epilepsy / Seizure _____
- ☐ Gout _____
- ☐ Headaches/ Migraines _____
- ☐ Heart Disease _____
- ☐ Hepatitis _____
- ☐ Herpes _____
- ☐ High Blood Pressure _____
- ☐ Kidney Disease _____
- ☐ Night Sweats _____
- ☐ Osteoporosis _____
- ☐ Skin condition _____
- ☐ Stroke _____
- ☐ Thyroid Disease _____
- ☐ TMJ issues _____

I use a C-PAP machine (circle) YES / NO

- ☐ Other: _____

_____

_____

I am a: (circle) CURRENT / FORMER smoker.

SOCIAL

On average I spent _____ hours in front of a screen (TV, computer, tablet, phone, etc.)

I am: (circle) single partnered married divorced widowed

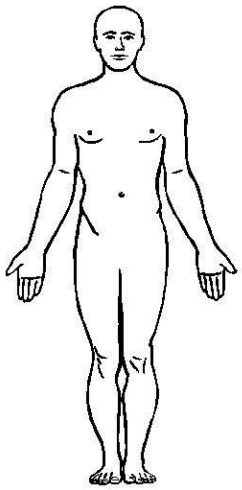
- ☐ I have children, ages: _____
- ☐ I am pregnant and due in: _____ Pregnancy concerns: _____

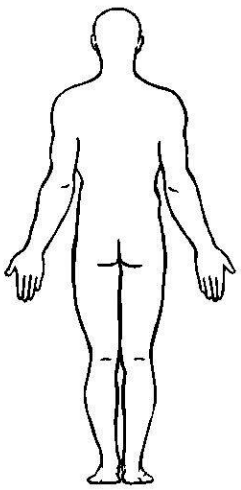
MEDICATIONS

Please bring a list of current medications or alternative treatments, what you take them for and how often you take them, how long you've taken them.

PAIN

Please indicate areas of pain, tightness, tension, and/or discomfort on the body chart.





ENERGY

- ☐ Sudden energy drop at _____ AM / PM
- ☐ Energy drop after meals
- ☐ High energy often
- ☐ Low energy often
- ☐ Fatigue
- ☐ Caffeine/ stimulant dependent
- ☐ Wired/ underground feeling
- ☐ Hard to concentrate
- ☐ Poor memory
- ☐ Dizziness/ lightheadedness
- ☐ Shortness of breath
- ☐ Heart Palpitations
- ☐ High / Low Blood Pressure
- ☐ Bleed / Bruise Easily
- ☐ Heartburn
- ☐ Headaches _____/ week
- ☐ Other energy concerns

DIGESTION

I usually have _____ bowel movements every day

My stools keep shape (circle) YES NO

- ☐ Irritable Bowel Syndrome
- ☐ Diarrhea often
- ☐ Constipation often
- ☐ Dry stools
- ☐ Foul smelling stools
- ☐ Indigestion
- ☐ Gas, Bloating, Belching
- ☐ Poor Appetite
- ☐ Excessive Hunger
- ☐ Nausea / Vomiting
- ☐ Bad Breath
- ☐ Heartburn

SLEEP

hours sleep/ night: _____

- ☐ Wake up _____ times/ night usually at _____ AM / PM
- ☐ Wake to urinate_____ times
- ☐ Difficulty falling asleep
- ☐ Restless sleep
- ☐ Disturbing dreams
- ☐ Not rested upon waking

EMOTIONS (what dominates?)

- ☐ Joy
- ☐ Anger
- ☐ Irritability
- ☐ Anxiety, Worry
- ☐ Sad / Depressed
- ☐ Grief
- ☐ Obsessive thinking
- ☐ Fear
- ☐ Indecision
- ☐ Timid / shy
- ☐ Numb / bored

MENSTRUATION:

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Clots
- ☐ Irregular periods
- ☐ Changes in body or psyche prior to period (PMS)
- ☐ Digestive changes with period
- ☐ Breast tenderness
- ☐ Cramps:
  - __ Before bleeding
  - __ First day only
  - __ During period
- ☐ Fatigue with period
- ☐ Yeast Infections
- ☐ Birth control

URINARY:

- ☐ Decrease in flow
- ☐ Incontinence
- ☐ Difficulty starting/ stopping
- ☐ Dribbling
- ☐ Kidney Stones
- ☐ Frequent urinations
- ☐ Pain with urination
- ☐ Urgency to urinate

REPRODUCTIVE:

- ☐ Decrease in sexual drive
- ☐ Discharge
- ☐ Erectile dysfunction
- ☐ Premature ejaculation
- ☐ Prostate disease
- ☐ Genital pain
- ☐ Hemorrhoids
- ☐ Fertility issues

EYES, EARS, NOSE & THROAT

- ☐ Dry eyes
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Night blindness
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Excessive ear wax
- ☐ Sinus congestion
- ☐ Phlegm
- ☐ Mouth sores
- ☐ Cough

MENOPAUSE: Age at last menses: _____ Year change began: _____

- ☐ Hot flashes: _____/ day / week
- ☐ Night sweats: _____/ day / week