



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 HEREBY 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 than 24 hours notice, then I must pay a \$30.00 late cancellation 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 cancellation 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 TO YOUR INITIAL APPOINTMENT.

# 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 \_\_\_\_\_
- Allergic to peanuts or tree nuts \_\_\_\_\_
- 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: \_\_\_\_\_

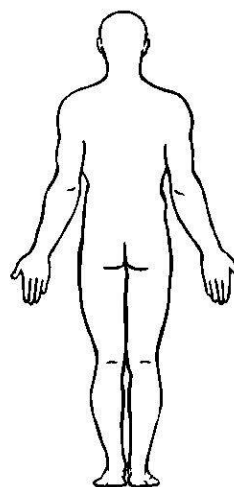
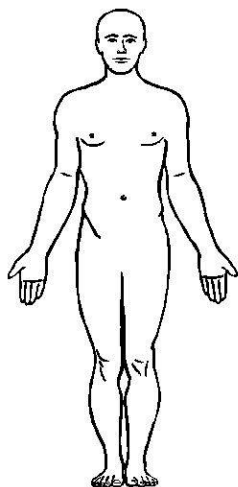
I am pregnant and due in: \_\_\_\_\_ Pregnancy concerns: \_\_\_\_\_

## 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

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

## DIGESTION

I usually have \_\_\_\_ bowel movements every day

My stools keep shape (circle) YES NO

- |   |  |
|---|--|
| <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Gas, Bloating, Belching |
| <input type="checkbox"/> Diarrhea often           | <input type="checkbox"/> Poor Appetite           |
| <input type="checkbox"/> Constipation often       | <input type="checkbox"/> Excessive Hunger        |
| <input type="checkbox"/> Dry stools               | <input type="checkbox"/> Nausea / Vomiting       |
| <input type="checkbox"/> Foul smelling stools     | <input type="checkbox"/> Bad Breath              |
| <input type="checkbox"/> Indigestion              | <input type="checkbox"/> Heartburn               |

## SLEEP

# hours sleep/ night: \_\_\_\_\_

- |  |
|--|
| <input type="checkbox"/> Wake up _____ times/ night usually at _____ AM / PM |
| <input type="checkbox"/> Wake to urinate _____ times                         |
| <input type="checkbox"/> Difficulty falling asleep                           |
| <input type="checkbox"/> Restless sleep                                      |
| <input type="checkbox"/> Disturbing dreams                                   |
| <input type="checkbox"/> Not rested upon waking                              |

## EMOTIONS (what dominates?)

- |  |   |
|--|---|
| <input type="checkbox"/> Joy             | <input type="checkbox"/> Obsessive thinking |
| <input type="checkbox"/> Anger           | <input type="checkbox"/> Fear               |
| <input type="checkbox"/> Irritability    | <input type="checkbox"/> Indecision         |
| <input type="checkbox"/> Anxiety, Worry  | <input type="checkbox"/> Timid / shy        |
| <input type="checkbox"/> Sad / Depressed | <input type="checkbox"/> Numb / bored       |
| <input type="checkbox"/> Grief           |   |

## MENSTRUATION:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Heavy periods                                   | <input type="checkbox"/> Light periods | <input type="checkbox"/> Cramps: _____ Before bleeding |
| <input type="checkbox"/> Painful periods                                 | <input type="checkbox"/> Clots         | _____ First day only                                   |
| <input type="checkbox"/> Irregular periods                               |  | _____ During period                                    |
| <input type="checkbox"/> Changes in body or psyche prior to period (PMS) |  | <input type="checkbox"/> Fatigue with period           |
| <input type="checkbox"/> Digestive changes with period                   |  | <input type="checkbox"/> Yeast Infections              |
| <input type="checkbox"/> Breast tenderness                               |  | <input type="checkbox"/> Birth control                 |

## URINARY:

- |  |
|--|
| <input type="checkbox"/> Decrease in flow              |
| <input type="checkbox"/> Incontinence                  |
| <input type="checkbox"/> Difficulty starting/ stopping |
| <input type="checkbox"/> Dribbling                     |
| <input type="checkbox"/> Kidney Stones                 |
| <input type="checkbox"/> Frequent urinations           |
| <input type="checkbox"/> Pain with urination           |
| <input type="checkbox"/> Urgency to urinate            |

## REPRODUCTIVE:

- |   |
|---|
| <input type="checkbox"/> Decrease in sexual drive |
| <input type="checkbox"/> Discharge                |
| <input type="checkbox"/> Erectile dysfunction     |
| <input type="checkbox"/> Premature ejaculation    |
| <input type="checkbox"/> Prostate disease         |
| <input type="checkbox"/> Genital pain             |
| <input type="checkbox"/> Hemorrhoids              |
| <input type="checkbox"/> Fertility issues         |

## EYES, EARS, NOSE &amp; THROAT

- |  |  |
|--|--|
| <input type="checkbox"/> Dry eyes        | <input type="checkbox"/> Excessive ear wax |
| <input type="checkbox"/> Red eyes        | <input type="checkbox"/> Sinus congestion  |
| <input type="checkbox"/> Itchy eyes      | <input type="checkbox"/> Phlegm            |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Mouth sores       |
| <input type="checkbox"/> Poor hearing    | <input type="checkbox"/> Cough             |
| <input type="checkbox"/> Ringing in ears |  |

MENOPAUSE: Age at last menses: \_\_\_\_\_ Year change began: \_\_\_\_\_

- |  |   |
|--|---|
| <input type="checkbox"/> Hot flashes: _____ / day / week | <input type="checkbox"/> Night sweats: _____ / day / week |
|--|---|