Flower Power Acupuncture

HEALTH HISTORY

Date:_____/ / _

Name, first and last (as you would like to be called):	Gender (identity):	Age:

Address:	City:	Zip Code:

Home Phone #:	Other Phone #: Work Cell Other	Email:

Date of Birth:	Emergency contact:	Contact #:	Relationship:

Best form of contact:	Want to join our mailing list?	If your legal name is different from your prefered name and you want us to have it, put here:

What pronouns would you like to be addressed by? (her, him, hir, they, etc.)	Occupation:

Physician:	Physician's Phone #:

How did you hear of our clinic? Who can we thank for the referral?	Have you been treated by acupuncture before? When was that?
	◯ No ◯ Yes / /

OFFICE USE ONLY

On the following page**s**, please **enter your medical concerns** and indicate **key events in your health history**.

Medical Intake Form

Name（姓名）: **Age（年齡）:** **Date（日期）:**

1: Main Complaint (主訴):

Length of Time (已經多長時間)?

What conditions alleviate the symptoms (有甚麼情況下症狀會減輕)?
(Heat, Cold, Damp Weather, or Exercise/Activity)
What conditions worsen the symptoms (有甚麼情況下症狀會加重)?
(Heat, Cold, Damp Weather, or Exercise/Activity)
Western Diagnosis (西醫診斷病名):

Western Prescriptions/Medications (現在服用哪些西藥, 草藥):

Past surgery (做過哪些手術):

Short Medically Related History (其他醫療相關健康史):

2: Physical Pain/Discomfort, Location (身體疼痛不適, 位置):
Physical Pain / Discomfort, Type (身體疼痛不適, 種類):
☐Sharp (劇痛) ☐ Dull (鈍痛) ☐ Pricking (刺痛) ☐Soreness (痠痛) ☐ Oppressive (悶痛) ☐ Weakness (無力) ☐ Tightness (緊) ☐ Fixed/Static (痛處固定) ☐ Moveable (痛處遊走) ☐ Radiating (放射狀疼痛)

3: Muscle cramping locations / Frequency (身體抽筋的部位 / 頻率):

4: Tremor locations / Frequency (震顫的部位 / 頻率):
Movement Disorders （運動障礙） ☐Limb tremors（肢體顫抖） ☐ Internal (Invisible) Tremors（內部（不可見的）顫抖）☐ Restless Legs（不寧腿）☐Tics (Irregular uncontrolled movement)（抽搐（不規則不受控制的運動）） ☐Convulsions / Seizures（抽搐/癲癇發作）

5: Skin disorders location (皮膚不正常的部位):
Skin disorders type (皮膚不正常的種類):
☐ Numbness (木) ☐ Oiling (出油) ☐ Electric (麻) ☐ Itching (癢) ☐ Scaling (脫皮) ☐ Cracking (龜裂)
☐ Dryness (乾) ☐ Rashes (疹子) ☐ Pus boil (膿包)
☐ Stubborn sores (瘡瘍 不愈)

6: Sweating （汗）:
Abnormal Sweating Location （不正常出汗之部位）:
☐ Night Sweating（盜汗／夜間流汗）☐ Spontaneous Sweating（自汗） ☐ Lack of Sweating（幾乎不流汗） ☐ Excessive Sweating（多汗) ☐Greasy, oily and yellow sweat（油膩汗黃汗）☐Sweating with Anxiety（焦虑出汗）☐Sweating with meals or spontaneously（饭后或自汗）

7: Aversion or dislike of weather conditions（怕或是不喜歡的天氣狀況）
☐ Aversion to Wind（怕風） ☐ Aversion to Cold without Sweating（怕冷無汗）☐ Aversion to Wind or Cold, air condition or drafts with Spontaneous or Excessive Sweating (因自發或過度出汗而厭惡風或冷,空調或是風扇) ☐ Aversion to Dampness or rainy weather（怕濕氣或下雨天） ☐ Aversion to Heat, summer and can't stand the hot weather（怕熱,夏天，不能忍受熱天） ☐ No Aversions (沒有反感)☐ Dislike cold inside or outside（不喜歡冷的環境）

8: Check the subjective feeling of the body and limbs（選出主觀的身體與四肢感覺）:

☐Freezing Body and Limbs(冷冻身体和肢体)

☐Normal Body Temperature with Cold Hands and Feet(正常体温，手脚冰凉)☐Heat in the Upper, Cold in the Lower(上熱下冷)☐Hot hands or feet at night(晚上手腳熱)☐Cold hands or feet at night(晚上手腳冰涼)☐Hot hands or feet during the day(白天手腳熱)

9: Headaches(頭痛)：☐ in the AM, with a clouded mind, feeling like a band（在上午，頭腦混亂）

☐ Vertex HA with heat, eye and gum pain(頭頂痛，伴有熱痛、眼痛和牙齦痛）☐ Temporal HA at night, with or without ear pain（夜間偏頭痛，伴有或不伴有耳痛）

☐ HA after sports or after menstruation（運動後或月經後）

10: Skin（皮膚）

☐Greasy, oily, itching, scaling, eruptions（膩癢、脫屑、出疹）☐Stubborn sores with pus, dark colored（頑固性膿瘡，深色）☐Skin spots with pain（疼痛的皮肤斑点）

☐Hot skin sensation, day or night（白天或晚上的皮膚熱）☐Acne on the face and skin（臉上和皮膚上長痘痘）

☐Acne only cyclically during menses（僅在月經期間週期性地長痘）☐Skin that is dry and cracking（皮肤干燥、龟裂）

11: Breathing(呼吸)

☐Wheezing with difficulty taking breath / Superficial breathing, shortness of breath(呼吸困難的喘息 / 淺呼吸、呼吸短促)☐Dry Cough(乾咳)☐Cough with white foamy phlegm(咳嗽伴有白色泡沫状痰)☐Cough with phlegm that is difficult to expectorate(咳嗽有痰难吐)☐Spastic cough at night(夜間痙攣性咳嗽)

12: Chest(胸)☐ Constant or occasional chest tightness（持續或偶爾胸悶）☐Chest tension and tightness after eating(飯後胸口緊繃) ☐ Chest pain on stress and hunger with tight diaphragm(壓力和飢餓引起的胸痛，隔膜緊繃)☐Heat in the lungs(肺熱) ☐Pain in the sternum(胸骨疼痛) ☐ Occasional and fixed rib side pain(偶爾固定的肋側疼痛)

13: Cough and Wheezing（咳喘）

☐ Dry Cough（乾咳） ☐ Profuse phlegm（痰多） ☐ With scant phlegm（少痰） ☐ Easy to expectorate（痰容易吐出） ☐ Hard to expectorate（痰不容易吐出）

☐ Difficult to lie down（沒辦法躺下） ☐ Yellow phlegm（黃痰） ☐ White phlegm（白痰） ☐ Foaming（泡沫痰）

Covid :☐ consumes body fluids(消耗體液)☐goes to the digestive system, Stomach and then Heart(進入消化系統，胃，然後心臟)☐Half and Half immediately(立即進入半表半里)☐Congests with dampness(濕阻)☐ Creates lingering heat in the chest(胸部余热)

14:Dryness（乾）

Dry Mouth （口乾）：☐No thirst, or dislike drinking（口乾不渴，或不喜歡喝水） ☐Thirst for sips（口乾，渴望喝一口） ☐With great/unquenchable thirst（口乾大渴/口乾無法止渴）

☐ Dry Throat（喉乾）：Either upon waking or end of the day（在醒來時還是一天結束時） ☐ Dry Eyes（眼乾）：Dry eyes after watching screens or reading（看營幕或閱讀後眼睛乾澀） ☐ Dry eyes, throat, nose and ears （眼睛、喉嚨、鼻子和耳朵乾燥）☐Vaginal Dryness（陰道乾澀） ☐Dry hair（乾髮）

15: ENT（五官）

Blurry vision（視力模糊）：☐ in the morning, improved with coffee or rubbing eyes（早上喝咖啡或揉眼睛後改善） ☐ in the morning with nausea and pain in the Stomach（早上，伴有噁心和胃痛 ） ☐ at the end of the day, or at night（在一天結束時，或在晚上）

Heat sensation in the eyes（眼睛有熱感）： ☐ Itching, redness, deposits（瘙癢，發紅，有沉積物）

☐ Pain（伴有疼痛）☐Triggered by overuse or fatigue（因过度使用或疲劳而引发）

Eye pain(眼痛): ☐Fixed, behind the eyes(在眼睛后面固定的疼痛)☐Worse with moving the eyes(移動眼睛疼痛更嚴重)☐If trauma(因爲外傷)

☐ Poor vision（視力不好） ☐ Floaters and Photophobia（飛蚊症或畏光）

Blocked sinus（鼻塞）:☐Constant(持續的) ☐Comes and goes(來來去去) ☐ Blocked in the evening, on fatigue, or with emotion(晚上、疲勞或情緒激動時阻塞)

Runny nose（流鼻涕) : ☐ Bentun(奔豚） ☐ with allergies（過敏流鼻涕）

☐ Sneezing（打噴嚏）☐ Post nasal drip（鼻后流涕）

☐ Loss of smell (嗅覺喪失) ☐ Nosebleeding (流鼻血) ☐ Itching (癢)

☐ Sudden Deafness（突發性耳聾） ☐ Reduced hearing in the evening (晚上聽力下降)

Tinnitus（耳鳴）:☐Low Pitch, comes and goes(低音，來來去去) ☐ High Pitch（高音）

Ear pain（耳痛) : ☐ Occasional(偶爾)☐ constant, maybe radiating to the jaw, or causing migraine(持续，可能会痛到下巴，或引起偏头痛)☐Severe ear pain（嚴重的耳痛）

☐ Ear Infection / Otitis(耳部感染/中耳炎)

☐ Tongue pain with heat sensation（舌痛伴熱感） ☐ Mouth ulcers（口瘡） ☐ Painful gums（牙齦痛） ☐ Receding Gums(牙齦萎縮) ☐ Tongue and Gum ulcers（舌和牙齦瘡） ☐ Tongue and Gum ulcers with swelling,reddness and pain（舌和牙齦潰瘍伴有紅腫脹痛）

16:Taste in mouth（嘴裡的味道）：☐ Neutral（正常）

☐ Bitter, Metallic, Abnormal（苦味、金屬味、異味） ☐ Sticky,Sweet, pasty taste in the mornings or after meals (早上或飯後有粘、甜、糕點味) ☐ Sticky,Sweet, pasty taste in the mornings or after meals accompanied with dirty smell,or smell of blood (早上或飯後有粘、甜、糊狀的味道，伴有髒臭或血腥味)

17: Thirst (渴)

☐ Not thirsty (幾乎不會口渴)

☐ Thirsty for cold drinks (口渴想喝冷的)

☐ Thirsty for warm/hot drinks (口渴想喝溫熱的) ☐ Thirsty but doesn't drink (口渴但又不想喝) ☐ Drinking causes nausea (喝東西之後會惡心) ☐ bloating or stomach pain after drinking (喝後會腹脹或胃痛) ☐ Drinking does not quench thirst (喝了之後還是不能解渴) ☐ Thirst at night (晚上比較口渴)

☐ Less than 4 cups a day (每天喝少於四杯流質) ☐ More than 8 cups a day (每天喝多於八杯流質)☐ Drink 1 glass of alcohol a day (每天喝一杯酒) ☐ Less than 1 glass a day (每天喝少於一杯酒) ☐ More than 1 glass a day (每天喝多於一杯酒) ☐ Others（其他飲料）? ☐ Coffee（常喝咖啡）? ☐ Green tea（ 常喝茶）? ☐ Energy drinks（常喝運動飲料）?

18: Appetite (胃口)

☐ Normal Good appetite(3meals), hunger within 30 minutes of waking（正常胃口好,三餐，醒來後 30 分鐘內飢餓)☐Small Appetite (2-3 meals) 胃口小（2-3 餐:）☐skipping breakfast, otherwise normal (不吃早餐，否則正常)☐Little food throughout the day 全天少食☐ No appetite (沒有胃口) ☐Large Appetite, 3++ meals (胃口大,3++ 餐) ☐Hungry after a large meal, or needs sweet (大餐后饥饿，或需要甜食) ☐ Large meal, 3x/day, with desire (大餐，3 次/天，有欲望)☐ Small meals several times a day (一天

幾次小餐)☐Hunger in the morning causing pain, urgency(早上飢餓導致疼痛，緊迫感) ☐No breakfast, big dinner or supper(没有早餐，大晚餐)

Food restrictions / allergies / IBS(食物限制/過敏/腸易激綜合徵): ☐Skin Reaction (皮膚反應) ☐ Intestinal Reaction (腸道反應) ☐Others 其他 :_____
Celiac(乳糜瀉) ☐ If radiating pain(如有放射痛) ☐ If sharp pain(如有放射痛)

☐ Snacks only (只吃零食) ☐ Smoothie only (只吃流質) ☐ Vegan (純素) ☐ Vegetarian (奶蛋素) ☐ Paleo (穴居人飲食)
Please list your common diet below (請列出您平常三餐吃甚麼):
Breakfast (早餐):

Lunch (午餐) :

Dinner (晚餐):

Supplements list (其他營養品, 補充品):

19: Abdominal Pain(腹痛)
☐Stomach Pain or blockage on hunger (before eating) 胃痛或飢餓時阻塞（進食前）☐Stomach Pain or blockage after eating (進食後胃痛或阻塞)☐Pain in the Lower Abdomen (下腹部疼痛)
Abdominal Bloating (腹脹)： ☐Bloating in the Upper Abdomen (上腹部脹) ☐Bloating of the Entire Abdomen (整個腹部脹)
Hypochondriac Cold Sensation(肋下冷)： ☐If with pain (如有痛) ☐ If no pain(如沒有痛)
☐Abdominal Heaviness (腹部沉重)

20: Urine (尿):
☐ normal flow, complete, not smelly or urgent, 0-1x nocturia after age 60（正常流量，排後無尿意，無異味或要尿很久，60 歲後 0-1 次夜尿）
☐ Less than 4 times per day, small amount(每天少於 4 次，少量) ☐ Over 6 times a day / frequent (每天多於6 次/頻繁)
Profuse, interrupted, hesitant, thin, urgent（大量、時斷時續、要尿很久、無力、緊急的）：☐If profuse（如果量多） ☐ if incontinence （如果失禁）☐ Painful with Bleeding（痛并流血）☐ Foamy, oily, and turbid（泡沫、油膩和渾濁）☐ Red/pink (紅或粉色) ☐ Clear (清淡無色) ☐ Light yellow(淡黃色) Dark yellow(深黃色) ☐Strong ordor (強烈氣味)
☐Night urination ___ times， around what time(晚上起床夜尿___次_____ 幾點)?
Hot or burning（熱或灼熱）：☐ If throughout urination（如在排尿過程中） ☐ If at the end of urination （如在排尿結束時）
UTI's 泌尿道感染：☐Recurrent （經常性）☐With Cloudy Urine （尿混濁）☐Particulates in the urine （尿有微粒）☐Bedwetting（尿床）

21:Bowel movement frequency (大便的頻率):
Stool (大便):
☐ Loose Stools, Unformed (like cow patty)（鬆散，不成形）
☐Dry, Difficult Stool（乾燥、難排便）☐Liquid Stools,Severe leakage that needs to be stopped immediately（水樣便，嚴重洩漏需要立即停止）☐Undigested Food（未消化的食物）
☐Alternating Stools, If changing from loose to formed or vice-versa（鬆散，未成形交替）☐Forceless and incomplete無力和之後仍有便意 ）☐ Sticky (黏) ☐ Bloody (血) ☐Strong ordor (強烈氣味)

22: Palpitation Frequency and Duration (心慌心跳發生的頻率與持續時間):
Palpitation (心慌心跳) ：☐ Day (發生在白天) ☐ Night (發生在晚上) ☐ Painful (伴隨心痛)
☐Tachycardia（心跳過速）
☐Bradycardia （心跳过缓）☐Bradycardia， If an athlete（如运动员心跳过缓）
☐Cardiac Pain （心痛）☐Cardiac Pain，Post-Meal（飯後心痛）
GERD (Reflux, Acid Regurgitation)：☐ Generally（一般反流，反酸） ☐ If there is burning sensation in the stomach area （反流，反酸，如胃部有燒灼感）

23: Vertigo Frequency and Duration（眩暈發生的頻率與持續時間）:
Vertigo (眩暈) ：☐ Day (發生在白天) ☐ Night (發生在晚上) ☐ Need to sit? (需要坐下？)

24: Sleep（睡眠）
Insomnia （失眠）：☐Excessive thinking, ruminating circular thoughts, planning（過度想東想西）
☐Agitation, can't sit still need to move around, need sustenance to sleep (glass of milk, snack, etc), and then ☐sleep with agitated sleep and dreams （躁動坐不住，需要四處走動，需要營養才能入睡（一杯牛奶，點心等），然後就睡得焦躁多夢）☐Too tired to sleep, very sensitive to sound, waking early（太累睡不着，对声音很敏感，早醒）☐Due to pain in the joints or muscles, tension, restless leg （被疼痛 打斷睡眠、不宁腿）
☐Violent Dreams（暴力的梦）
☐Restless agitation（躁動不安）
☐Waking Easily / Early（易醒/早醒）
☐Waking Tired（醒来還是累）
☐Waking Heavy heavy, swollen, puffiness（醒來沉重、腫脹、浮腫）
☐Not getting tired (Night Owl's)（不累，夜貓子）
☐ Less than 2hrs（少於兩小時） ☐ 2 to 4 hours（兩到四小時） ☐ 4 to 6 hours（四到六小時） ☐ Over 6 hours（六小時以上）

25: Emotions（情緒）:
☐Rage（憤怒）
☐Disconnected（疏離感）
Depression / Sadness （抑鬱/悲傷） :
☐Digestion-related; Apathy - Don't know what to do with life（消化相关的; 冷漠 - 不知道如何處理生活）
☐Feeling stuck, trapped, have to move（感覺卡住被困住了，必須移動）☐Why me? Can't see a way out, negative outlook（為什麼是我？ 看不到出路，負面前景）☐Post-partum or seasonal（產後或季節性）
☐No desire to live（没有活下去的欲望）☐Long period of stress or overwork（长期压力或过度劳累）
☐Don't want to connect（不想連結）
☐Stuck（卡住）
☐Sensitive, easily moved to crying（易感易哭）
☐Dissatisfied（不滿意）
Overwhelmed （不知所措）：☐Body Fluid Depletion （因體液消耗）☐Post-Covid frustration（疫情后的挫敗感）
☐Passive Aggressive（被動式有攻擊性）
☐Paranoia（偏執狂）
☐Fear（恐懼）
☐Dreams of deceased people or animals（夢見死去的人或動物）
☐Hearing voices（聽到聲音）
☐Sexual Dreams （性夢）

26: Male Disorders (男性疾病): ☐ Prostatic fluid in urine (小便內有前列腺液 / 精液) ☐ Scrotal itching (陰囊發癢) ☐ Scrotal dampness (陰囊潮濕) ☐ Scrotal pain (陰囊痛) ☐ Perineal soreness (陰部痠痛
) ☐ Excessive Libido (性慾過旺) ☐ Soft Erections (勃起不全)
☐ Premature ejaculation (早洩) _____ time 次數/ ☐week 周, ☐month 月
☐ Spermattorhea (遺精)
_____ time 次數/ ☐week 周, ☐month 月 ☐ Impotence (性無能) Duration (有多久了): _____
☐ Low Libido (性慾低) Duration (有多久了): _____
☐ Infertility (不孕症)
☐ Low Sperm motility (精子活動力不佳) ☐ Low Sperm Quality (精子質量不好)☐ BPH (Benign Prostatic Hypertrophy)（良性前列腺肥大）☐Warts（疣）

27: Women Disorders（婦女病）**:**
Leucorrhea（白帶）: ☐ Profuse（量多） ☐ Strong smell（味道重） ☐ Scant（量少）
☐ Vaginal dryness（陰道乾燥） ☐ Vaginal itchiness（陰道癢） ☐ Vaginal pain（陰道痛） ☐ Vaginal sores（陰道瘡） ☐ Low libido（性欲低落） ☐ Excessive libido（性欲過度旺 盛） ☐ Breast pain（乳房疼痛） ☐ Uterine fibroids（子宮肌瘤） ☐ Pelvic pain（骨盆痛） ☐ Thick endometrium（子宮內 膜過厚
） ☐ Ovarian Cyst（卵巢囊腫）
Breast nodules (乳房腫塊) : ☐ Not painful, always there (不痛，一直有) ☐With emotions and stress (帶著情緒和壓力)☐Red and angry (又紅又生氣)
Menstrual Conditions（月經情況）: ☐ Regular（正常）
☐ Early or Late（經早或經遲）☐ Every 2-6 months （每 2-6 個月）
Bleeding Time (出血時間): ☐ Acne（長粉刺） ☐ Surge of Acne, Breast Pain, or Nausea(痤瘡、乳房疼痛或噁心的激增)
☐ Painful lesser abdomen（小腹痛） ☐ Abdominal bloating（腹部脹） ☐ Sore lower back（下背部／腰痠） ☐ Pain radiating in the legs（痛放射到腳 ） ☐ Soreness of the breast（乳房痠痛） ☐ Cold low back, abdomen（下背部／腹部 冷） ☐ Low appetite or nausea（食慾不良或噁 心）
☐ Mood fluctuation（情緒起伏） ☐ Spontaneous sweating（自汗）
Bleeding condition (流血的狀況):
☐ Bleeding less than 3 days (少於三天) ☐ From 3 to 5 days (三至五天) ☐ Bleeding over 5 days (多於五天
) ☐ Spotting (斷斷續續) ☐ Nonstop (流血不止)
☐ Red (紅) ☐ Brown (褐色) ☐ Dark (暗紅) ☐ Light (色淡)
☐ Scant (量少) ☐ Profuse (量多) ☐ Excessive Bleeding(過多)
☐ With clots (有血塊) ☐Clotting, Not painful, always there(一直有血塊,但不痛)
☐Amenorrhea(閉經)

28: Others
☐Water Qi (Edema)(水腫)
☐Energetic Sensitivity -
other people's energy, maybe chemicals, radiation?(能量敏感度-敏感其他人的能量，也許是化學物質，輻射？)
Bi-Syndrome(痺症) :☐ If paralysis (如癱瘓) ☐ In the chest(在胸口)
Bentun Symptoms(奔豚症):☐Insomnia(失眠)☐Vertigo(眩暈)☐Anxiety / Panic Attacks(焦慮/驚恐發作
)☐Depression(沮喪)☐Vomiting(嘔吐)☐Chest oppression(胸悶)☐Cough(咳嗽)
☐Runny Nose(流鼻涕)

Consent Form

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 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(s) who now or in the future treat me.
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 while this document describes the major risks of treatment, other side effects and risks may occur.

ACUPUNCTURE
I have been informed that acupuncture has been widely proven to be a safe method of treatment, but that it may have some side effects. These may include bruising, bleeding, needle breakage, numbness or tingling pain or other strong sensation near the needling sites that may last a few days or radiating from that location, aggravation of current symptoms (healing crisis), increased pain, appearance of new symptoms, or general aches and pains. And rarely dizziness, fainting or syncope. Very unusual risks of acupuncture include nerve damage, injury to blood vessels and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, skin irritation and infectious disease transmission, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

HERBS
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 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 the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbal formulas. Infrequent possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that some herbs may be inappropriate during pregnancy. I will notify the acupuncturist 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. I will notify the acupuncturist who is caring for me if I am, or become, pregnant.

MOXIBUSTION, CUPPING, GUA SHA (SKIN SCRAPING), HEAT LAMPS
Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising and discomfort are common side effects of cupping and gua sha.

GENERAL
I do not expect the acupuncturist to be able to anticipate or explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment, which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

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 acupuncturist 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.

Any care, treatment, and services provided within the scope of the acupuncturist's practice is not a substitute for care, treatment, and services by a licensed physician regarding the patient's condition.

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.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, have had an opportunity to ask questions and discussion, have agreed and have a clear understanding the treatment as described. 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.

ACUPUNCTURIST NAME: Nico Bishop L.Ac

PATIENT SIGNATURE (Or Patient Representative) : _____
Date: _____

Financial Policy

Payment is due at the time of treatment. The sustainability of our clinic depends on our patients keeping their appointment times or making them available to others who need them in a timely fashion. We ask for 48 hours' notice for any rescheduling or cancellation so that we may fill the appointment time. All appointments that are rescheduled or cancelled with less than 48 hours' notice and appointments missed without notice will be charged a $25.00 fee for that appointment.

I agree to the above policy. Signature_____

Nico Bishop, Licensed Acupuncturist (Lic # AC15205)

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 (Initial in all seven places provided) **Initial Below**

- 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. _____
- 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. _____
- 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. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *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. _____
- 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. _____
- I have been offered a copy of this consent form. _____

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 OF 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 IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature: _____	Parent / Guardian Signature _____	Witness Signature _____
Name _____	Name _____	Name: _____
Date _____	Date _____	Date: _____