One World Acupuncture

646 Central Street, Unit 1-C
Leominster, MA 01453

978-342-4400

One World Acupuncture Registration & New Patient Form

Name: _____ **Preferred Nickname:** _____

Address: _____ **City:** _____ **State:** **Zip:**

Date of Birth: _____ **Gender or Preferred Gender Pronoun:** _____

Occupation: _____ **Best Phone Number:** _____

Email Address: _____

Medical Doctor (Primary): _____

Have You Had Acupuncture Previously? ☐ Yes ☐ No

How Did You Hear About Us? _____

What are your primary concerns for coming in for treatment? Can list more than one

Are there any other concerns you'd like us to know about?

How long has it been since your last Physical Exam?

Are you currently taking any medication? Please List. ☐ **Yes** ☐ **No**

Do you have trouble with Digestion? ☐ **Yes** ☐ **No** (describe:)

How do you sleep? ☐ **None** ☐ **Light** ☐ **Moderate** ☐ **Heavy**

Check illnesses that have occurred in blood relatives.

☐ Diabetes ☐ Cancer ☐ Stroke ☐ Heart Disease ☐ High Blood Pressure ☐ Kidney Disease

Check symptoms you have or have had in the last year:

☐ Overwhelmed by life	☐ Depression	☐ Excessive Worry
☐ Difficulty in Focusing	☐ Dizziness	☐ Excessive Fear
☐ Easily Startled	☐ Headaches	☐ Loss or Gain of Weight
☐ Loss of Sleep/ Poor Sleep	☐ Excessive Anger	☐ Fatigue/Tiredness
☐ Autoimmune Disease	☐ Shingles	☐ Nervousness/Irritability

Check conditions you have or have had in the past:

	☐ Bleeding Disorders		☐ AIDS	☐ Allergies
☐ Diabetes	☐ Breast Lump	☐ Arthritis	☐ Cancer	☐ Anemia

DATE _____

NAME: _____

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Highlight symptoms you have or have had in the last year

MUSCLE/JOINT/ BONES

- Tremors or Cramps
- Swollen Joints

PAIN/WEAKNESS/ NUMBNESS

- Arms
- Hips
- Legs
- Feet
- Neck
- Hands
- Shoulders
- Back

Other: _____

GASTROINTESTINAL

- Belching, Gas or Bloating
- Distention of Abdomen
- Gall Bladder Trouble
- Pain Over Stomach
- Hemorrhoids (piles)
- Excessive Hunger
- Difficulty Swallowing
- Colon Trouble
- Constipation
- Indigestion
- Poor Appetite
- Vomiting
- Diarrhea
- Nausea

EYES/EAR/NOSE/THROAT/ RESPIRATORY

- Blurred or Failing
- Ringing in Ears
- Difficulty Breathing
- Hoarseness
- Asthma/ Wheezing
- Gum Trouble
- Persistent Cough
- Nose Bleeds
- Frequent Colds
- Hay Fever
- Enlarged Glands
- Earache
- Sinus Problems
- Eye Pain
- Loss of Hearing

SKIN

- Boils
- Sensitive Skin
- Bruise Easily
- Sweats
- Itching/ Rash
- Dry Skin
- Sore won't Heal

GENITO/ URINARY

- Inability to Control Urine
- Blood/Pus in urine
- Kidney Infection
- Frequent Urination
- Kidney Stones
- Lowered libido

CARDIOVASCULAR

- High or Low Blood Pressure
- Rapid/ Irregular Heart Beat
- Hardening of Arteries
- Previous Heart Attack
- Poor Circulation
- Pain Over Heart
- Swelling of Ankles
- Chest Pain

FOR MEN ONLY

- Erection Difficulties
- Penis Discharge
- Prostate Trouble
- Male Infertility

FOR WOMEN ONLY

- Bleeding Between Periods
- Scanty Menstrual Flow
- Excessive Menstrual Flow
- Clots in Menses
- Extreme Menstrual Pain
- Irregular Cycle
- Menopausal Symptoms
- PMS
- Previous Miscarriage

Fertility Questions

1. How long have you been trying to get pregnant? _____

2. What (if any) is the primary diagnosis? _____

3. Have you sought fertility specialist? ◦ **Yes or** ◦ **No**

4. What type of treatments (if any) have you tried? Please list.

The information on this form is correct to the best of my knowledge.

Signature: _____ Date:

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Financial Policy

One World Acupuncture is a low-cost, high volume Community Acupuncture Clinic. Our fees are $20-$40 per treatment. You decide what you can pay at each visit. We never ask for income verification and trust that you know best what you can afford to pay for your treatment. We make every attempt to make acupuncture available to as many people as possible at the most affordable rates. This is our mission.

Payment is expected at the time of your visit. We accept checks, cash, VISA and MasterCard, Amex & Discover. We ask that you be prepared to pay for your treatment each time you come in. At anytime you may change the amount that you pay on the sliding scale up or down. If you need a receipt to submit to your insurance, please let us know. We'd also be happy to give you a cash receipt as well. Just ask. We reserve an appointment time for you and ask that you call us if you cannot keep your appointment. In consideration of other folks who may be on a waiting list for appointments, we ask that you give us at least 12 hours notice in advance of an appointment that you'll not be able to keep.

All appointments that are canceled with less than 12 hours notice, or are missed altogether without letting our front desk know, will be charged the appointment fee.

We do also recognize that emergencies happen, and would be happy to consider these on an individual basis, of course. Thanks for understanding and in doing so, helping us to keep our fees as low as possible.

☐ I understand that all prepaid packages are non-refundable after 7 days from purchase. Prepaid packages expire one year from the date of purchase and can be shared with one household member.

I have read and agree to the above policies:

Print Name:_____

Signature:_____ Date:_____

Informed Consent

Acupuncture involves the insertion of special needles into particular points on the body. The purpose of this treatment is to prevent or reduce pain and to help your body function better. There are some risks to treatment, including bruising of the skin and/or slight bleeding, weakness, fainting and aggravation of symptoms existing prior to acupuncture treatment. There is little to no risk of infection when all needles are sterile. OWA uses only one-time use, sterile disposable needles. We do not reuse needles, even at different areas of the body for the same person.

We do not provide primary care, nor Western (allopathic) medical care. Please see your medical doctor for those services and for routine check-ups. If you are pregnant, have a bleeding disorder, pacemaker, high blood pressure, seizure disorder, local infection or have been prescribed anticoagulant (blood thinning) medications like Coumadin, by signing below you state that you have informed your acupuncturist of such conditions.

With this knowledge, I voluntarily consent to the above procedures.

Print Name:_____

Signature:_____ Date:_____