

One World Acupuncture Registration & New Patient Form

Name: _____ **Preferred Nickname:** _____
Address: _____ **City:** _____ **State:** _____
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:

- | | | |
|--|--|---|
| <input type="checkbox"/> Overwhelmed by life | <input type="checkbox"/> Depression | <input type="checkbox"/> Excessive Worry |
| <input type="checkbox"/> Difficulty in Focusing | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Excessive Fear |
| <input type="checkbox"/> Easily Startled | <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss or Gain of Weight |
| <input type="checkbox"/> Loss of Sleep/ Poor Sleep | <input type="checkbox"/> Excessive Anger | <input type="checkbox"/> Fatigue/Tiredness |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Shingles | <input type="checkbox"/> Nervousness/Irritability |

Check conditions you have or have had in the past:

- | | | | |
|--------------------------------------|---|---------------------------------|------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> AIDS | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Anemia |

Highlight symptoms you have or have had in the last year

MUSCLE/JOINT/ BONES	
<ul style="list-style-type: none"> ◦ Tremors or Cramps ◦ Swollen Joints 	

PAIN/WEAKNESS/ NUMBNESS	
<ul style="list-style-type: none"> ◦ Arms ◦ Legs ◦ Neck ◦ Shoulders ◦ Hips ◦ Feet ◦ Hands ◦ Back <p>Other: _____</p>	

GASTROINTESTINAL
<ul style="list-style-type: none"> ◦ 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	
<ul style="list-style-type: none"> ◦ Blurred or Failing ◦ Difficulty Breathing ◦ Asthma/ Wheezing ◦ Persistent Cough ◦ Frequent Colds ◦ Enlarged Glands ◦ Sinus Problems ◦ Loss of Hearing ◦ Ringing in Ears ◦ Hoarseness ◦ Gum Trouble ◦ Nose Bleeds ◦ Hay Fever ◦ Earache ◦ Eye Pain 	

SKIN
<ul style="list-style-type: none"> ◦ Boils ◦ Sensitive Skin ◦ Bruise Easily ◦ Sweats ◦ Itching/ Rash ◦ Dry Skin ◦ Sore won't Heal

GENITO/ URINARY
<ul style="list-style-type: none"> ◦ Inability to Control Urine ◦ Blood/Pus in urine ◦ Kidney Infection ◦ Frequent Urination ◦ Kidney Stones ◦ Lowered libido

CARDIOVASCULAR
<ul style="list-style-type: none"> ◦ 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
<ul style="list-style-type: none"> ◦ Erection Difficulties ◦ Penis Discharge ◦ Prostate Trouble ◦ Male Infertility

FOR WOMEN ONLY	
<ul style="list-style-type: none"> ◦ Bleeding Between Periods ◦ Excessive Menstrual Flow ◦ Extreme Menstrual Pain ◦ Menopausal Symptoms ◦ Previous Miscarriage ◦ Scanty Menstrual Flow ◦ Clots in Menses ◦ Irregular Cycle ◦ PMS 	

Fertility Questions
<p>1. How long have you been trying to get pregnant? _____</p> <p>2. What (if any) is the primary diagnosis? _____</p> <p>3. Have you sought fertility specialist? ◦ Yes or ◦ No</p> <p>4. What type of treatments (if any) have you tried? Please list.</p> <p>_____</p> <p>_____</p>

The information on this form is correct to the best of my knowledge.
Signature: _____ Date: _____

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. 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 a \$10.00 fee payable at the next visit.

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 agree to the above policy:

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: _____