Date____/____/_____

Acupuncture New Patient Questionnaire

Name_____ Age_____ Birthdate____/____/_____

Address_____ City_____ State_____ Zip_____

Phone (Home) _____ (Cell) _____ (Other) _____

Email_____ Preferred Contact Method: (Home, Cell, Other, Text, Email)

Gender: (*Male or Female*) Marital Status: (*Single, Married, Divorced, Widowed, Separated, Partnered*)

Occupation_____ (*full or part time*) Employer_____

Name of spouse (or parent for minor child)_____ Phone_____

Emergency Contact_____ Phone_____

How did you hear about our office?_____

Last physician or health care provider seen?_____

Reason for visit?_____

_____

Do you have a diagnosis regarding this issue? _____

_____

Allergies?_____

Childhood illness or accidents birth to 18?_____

Major illnesses, surgeries and accidents from age 18 till present?_____

_____

Medication list, including herbs, supplements, and pharmaceuticals?_____

_____

Scars please list any major scars with location, size and color?_____

Do you have pain anywhere?_____

Where?_____

Do you smoke?_____

If yes, how many cigarettes/cigars/vapes per day?_____

Do you have any problems sleeping? _____

Any emotional issues present or past? _____

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Any family history of serious disease? _____

Any urogenital disorders?_____

Women only; any issues around menstruation e.g. cramps, mood changes?_____

_____

Length of cycle: _____

When was your last period? _____

Are you pregnant? _____

Are you on a diet? _____

What is a normal meal for you? _____

Acupuncture Informed Consent

I, _____, the undersigned agree to be treated by Tim Iliff LAC with acupuncture and or other modalities of oriental medicine including, but not limited to moxibustion, guasha, cupping, tuina and shonishin.

I, _____, understand that all treatment methods have risks and the risks associated with oriental medicine include, bleeding, bruising, soreness, pain, rashes and in rare cases pneumothorax, organ puncture and even death.

I, _____, am aware that I have other options for treatment including, but not limited to Chiropractic, massage, energy healing, faith healing, drug therapy and surgery.

I,_____, hereby release Tim Iliff LAC from liability due to any injury or harm, actual or perceived that I may receive while under their care.

I,_____, understand that 48 hours' notice is required to cancel an appointment, except for emergencies and that if less than 24 hours' notice is given that I will be responsible for the full price of the appointment.

Signed,_____ Date_____

Witnessed By, _____