

## New Patient Information

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Apt.# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

e-mail address: \_\_\_\_\_

Referred By: \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_ Sex: M/F Height \_\_\_\_\_ Weight \_\_\_\_\_

Overall health (circle one): Excellent / Good / Fair / Poor / Other: \_\_\_\_\_

Chief complaint (current symptoms reason you are here): (use separate sheet if more room needed) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Previous treatments for this complaint \_\_\_\_\_

\_\_\_\_\_

Current medications/drugs being taken: (use separate sheet if needed) \_\_\_\_\_

\_\_\_\_\_

Are you currently under the care of a physician or other healthcare professionals?

(If yes, please give name and date of last visit):

\_\_\_\_\_

Nutritional supplements you are taking: \_\_\_\_\_

\_\_\_\_\_

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes \_\_\_\_\_ Coffee \_\_\_\_\_ Alcohol \_\_\_\_\_

Is your diet (circle one): Excellent / Good / Fair / Poor / Other: \_\_\_\_\_

Is nutritional support something you are interested in? Yes/No

**HISTORY**

List any major illnesses (with approx. dates): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any surgery or operations with approx. date: \_\_\_\_\_

\_\_\_\_\_

Past Accidents or injuries: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Consent to Treat**

By signing below, I do hereby voluntarily consent to be treated with acupuncture by licensed acupuncturist, Amy Satterfield, L.Ac. I understand that acupuncturists practicing in the states of Missouri are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this practitioner.

**Acupuncture**

I understand that acupuncture is performed by insertion of needles through the skin in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects, although rare, may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain, or discomfort, and possibly temporary aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

**Notice of Privacy Practices and Patient Rights**

I acknowledge that I have received a copy of the Notice of Privacy Practices and Patient Rights and have had an opportunity to ask questions about it. All questions I have asked have been fully answered. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask the practitioner for a more detailed explanation. I give my permission and consent to treatment.

**Contact Information**

Printed Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

In case of emergency please  
contact: \_\_\_\_\_ Relationship \_\_\_\_\_

Phone number(s): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_