



Titusville Acupuncture

WELLNESS CENTER

1508 Garden Street
Titusville, FL 32796
321-225-4565

Welcome to Titusville Acupuncture Wellness Center.

We are honored that you have chosen us to be part of your healthcare team.

It is our priority to insure that you are comfortable and receive the very best in patient care.

If there is anything we can do to make your experience even better, please let us know.

Patient Intake

Today's Date _____

Name: _____ Birthdate: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone: _____ Cell Phone: _____

Which of the following methods may we contact you? Please circle all that apply.

Home Phone

Cell Phone

Text Message

Email

How did you hear about our office? _____

Have you received acupuncture before? Y N

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

Are there any family members, friends or care givers that you wish us to be able to discuss or release your medical information? If so, please list: (you may update or change at any time by contacting our office)

Patient/Guardian Signature _____



Today's Date: _____

Name: _____ Birthdate: _____

Please complete the following questions:

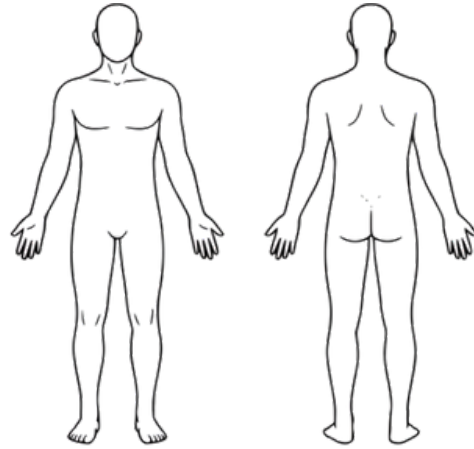
1) Current Conditions/Complaints:

1. _____
2. _____
3. _____

2) Current Pain Level

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

Mark an X on the picture where you have pain or other symptoms



3) In the past week, on average, how often have your symptoms been present? (circle)

Occasional 0-25% 26-50% 51-75% 76-100% Constant

4) In the last week, how much has your pain symptoms interfered with your daily activities?
(e.g., work, social activities, or household work)

0 1 2 3 4 5 6 7 8 9 10
No Interference Unable to carry on activities

5) In general, would you say your overall health right now is:

excellent very good good fair poor

6) Please provide a brief history of your current complaints. (use back if necessary)

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this practitioner whenever I have changes in my health condition while under care.

Patient Signature: _____



Consent To Treatment

I, _____, voluntarily consent to receive acupuncture and/or Chinese herbal medicine treatment administered by Eric Hunstad, AP L.Ac who is licensed by the State of Florida and is certified by the National Certification Commission of Acupuncture and Oriental Medicine (NCCAOM) to practice acupuncture and Chinese herbology.

I have provided a full history and description of complaints which is complete and accurate. I understand the need for communication with all of my healthcare providers regarding my health status is ongoing and necessary. I understand that no guarantee has been made concerning the use and effects of acupuncture and Chinese herbal medicine. I understand that I may stop treatment at any time.

I understand that acupuncture is the insertion of fine sterile needles, with or without the addition of electrical stimulation, through the skin. I understand that treatment may also include the application of heat, red light, or laser.

I acknowledge that, although rare, certain side effects may result from acupuncture, heat therapy, and Chinese herbal medicine. Possible side effects include minor bruising, minor bleeding, some pain, numbness, and/or tingling at the site of the needle insertion, infection (extremely rare- the clinic uses sterile, single use, disposable needles, maintains a clean and safe environment, and utilizes universal precautions). Other side effects may include dizziness and fainting (please eat a small meal prior to treatment to prevent this). These events are unusual and of short duration. Rare but potential side effects of heat therapy include heat discomfort or burning. Side effects of Chinese herbal medicine are rare but may include allergic reactions. Strong cleansing responses to acupuncture, Chinese herbal medicine, or cleansing/detoxing may also occur (your provider will always discuss this with you prior to treatment if there is a possibility of this based on what treatment/formulas you are receiving).

I will notify a staff member if I am or become pregnant.

I understand the clinical and administrative staff may review my patient records, imaging reports, and lab reports, but all of my patient records will be kept confidential and will not be released without my permission.

By voluntarily signing below, I show that I have read the above consent to treatment, have been told about the risks and benefits of acupuncture and related procedures, and I have the opportunity to ask questions at any time. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Signature _____ Date _____