

Groupon Acupuncture Intake Form

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Phone _____ Mobile, Work, Home (circle)

Date of Birth _____ Male _____ Female _____

Email _____

Would you like to receive our Free Monthly Newsletter? Yes _____ No _____

Occupation _____ Marital Status _____

In case of emergency notify _____

Relationships to you _____ Phone No _____

What specific problem are you seeking treatment for: _____

Are you currently taking any narcotics for pain? _____

Are you currently taking any blood thinners or psychiatric medications for anxiety, depression, or PTSD? _____

Have you had to go to the emergency room or hospital for the level of pain that you are experiencing? _____

Is your pain the result of a recent automobile accident? _____

Have you ever received acupuncture treatment? Yes ___ No ___

Are you interested in followup visits after Groupon? Yes ___ No ___

PATIENT INTAKE FORM

Name _____ Date _____

NOW: PREGNANT PACEMAKER AIDS HEPATITIS BLOOD TRANSFUSION

FAMILY HISTORY:

Abuse AIDS Alcoholism Allergies Asthma Cancer Diabetes
 Drugs Heart Disease High Blood Pressure Respiratory Diseases Seizures
 Stroke Other _____

YOUR PAST MEDICAL HISTORY/ILLNESSES:

Aids Alcoholism Arthritis Asthma Auto Immune Disease Bronchitis Cancer
 Chronic Fatigue Syndrome Chronic Lung Disease Diabetes Drugs Heart Disease
 Hepatitis Hernia High Blood Pressure Kidney Disease Organ Transplant Pneumonia
 Rheumatic Fever Seizures/Epilepsy Sexually Transmitted Diseases (STD) _____
 Thyroid Disease Tuberculosis Ulcers Vaccine Reaction Whooping Cough

SURGERIES: (Please include dates)

1. _____
2. _____
3. _____

TRAUMATIC INJURY: (Please include dates)

Car accident _____
Falls _____
Other _____

ALLERGIES:

Drugs _____
Chemicals _____
Food _____
Others _____

CURRENT MEDICATIONS:

OCCUPATIONAL/ENVIRONMENTAL EXPOSURES OR HAZARDS:

Chemical: _____ Acid/Alkalines: _____
Heavy Metals: _____ Physical Labor: _____
Electrical: _____ Psychological: _____

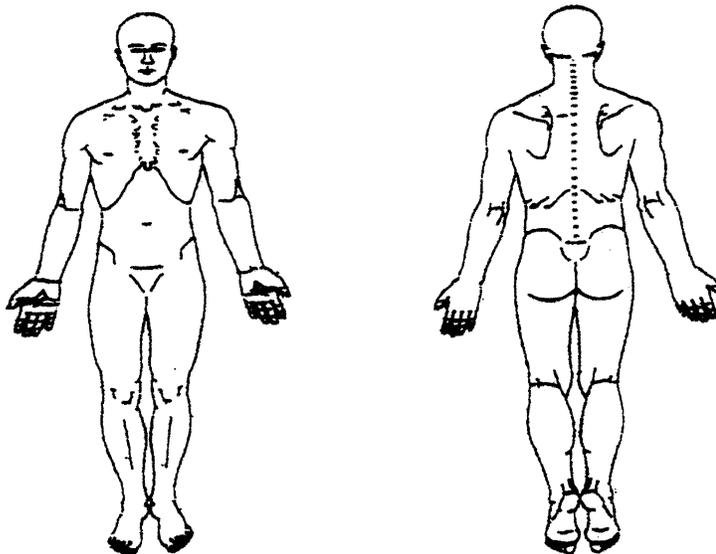
HABITS/EXCESSIVE USAGE:

alcohol chocolate cigarettes coffee cola drugs exercise food salt
 sex sugar tea other _____

CHIEF COMPLAINT / REASON FOR COMING IN:

Pain Assessment

A. Where is the location of your pain? Please clearly mark on the diagram:



- B. Please rate the level of your pain at present from a scale of 1-10(10 is the most severe) _____
- C. What is the quality of your pain(ie. aching, burning, stabbing, dull) _____
- D. Pain is Constant _____ YES _____ NO
- E. If pain is not constant than how often does it occur? _____
- F. How long have you had your pain?
_____Hours_____Days_____Weeks_____Months_____Years
- G. Did the pain start gradually or suddenly? _____
- H. Do any of the following lessen the pain?
_____Pressure_____Heat_____Cold_____Movement(Which movement) _____
- I. Do any of the following make the pain worse?
_____Pressure_____Heat_____Cold_____Movement(Which movement) _____
- J. Is there anything else that relieves your pain? _____
- K. Is there anything else that makes your pain worse? _____
- L. Please circle of your pain has had some effect on any of the following: sleep activity level emotions ability to concentrate appetite relationships
- M. Please list or describe any prior treatments that you have had regarding your condition _____

Dr. Glenn H. Osterweil, DOM, LAc, DPM
Florida Institute of Acupuncture & Herbal Medicine

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Dr. Glenn H. Osterweil, DOM, LAc, DPM, Florida Institute of Acupuncture & Herbal Medicine, and staff who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Glenn H. Osterweil, D.P.M., L.Ac., Florida Institute of Acupuncture & Herbal Medicine, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese Herbal Medicine, nutritional counseling, acupoint injection therapy, and homeopathic remedies. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell and taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant side effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness, or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant. I will notify a clinical staff member who is caring for me if I have a severe bleeding disorder, have a history of seizures, or a pace maker PRIOR to any treatment.

I do not expect Dr. Glenn H. Osterweil, DOM, LAc, DPM or the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgement during the course of

treatment which the clinical staff thinks at the time, based on the facts then known is in my best interest. I understand the results are not guaranteed.

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

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition(s) for which I seek treatment.

I understand that there is neither an implied nor stated guarantee of success or effectiveness of treatment. I hereby authorize Dr. Glenn H. Osterweil, DOM, LAc, DPM, Florida Institute of Acupuncture & Herbal Medicine, to release any information regarding my condition to the referring physician(if any) and/or to my insurance for the processing of any claim. I also authorize Dr. Glenn H. Osterweil, DOM, LAc, DPM, Florida Institute of Acupuncture & Herbal Medicine, to obtain my medical records from other physicians or medical centers.

Signature: _____ Date: _____

Patients Representative or Parent _____