WELCOME

Pinnacle Integrative Health PC
509 Olive Way Ste 803 Seattle WA 98101
206-624-0397

Patient Information

Date:________________________

Name:
Last________________________________ First_____________________________________ MI____________

Email address: ____

Mailing Address: ____
Street City/State/Zip Code

Phone # (Cell)_________________________ (W) ________________________ (H) ____________________

Date of Birth:_______________ Age:_______ Sex: ❑ Male ❑ Female SS#: ____________________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Ethnicity: ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other _____

❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Occupation: ___________________________________ Employer: _____________________________________

Employer Address: ____ Phone: __________________________

How did you hear about our practice? ____

Emergency contact: Name: ____________________ Relation: _______________ Phone #: _____________________

Phone #: (H) _______________________ (W) ______________________

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other ___________

Has it been reported? ❑ Yes ❑ No If yes, to whom? ______________________________________

Insurance Information

Policy Holder Name: ____ D.O.B. :____________________________

Relationship to patient (if other than self): ___________________________ Phone # ______________________________
Do you have health insurance? ❑ Yes ❑ No Name of Carrier: ___________________________________
Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: ___________________________________
Who is your primary care physician? (doctor and/or practice) ____

NOTE>> PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with ________________________ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) ____ **DATE** ____________________________

Appointment Cancellation Agreement:

I understand that twenty-four (24) hours notice is not only appreciated, but also required when cancelling an appointment. I understand that I will be charged $60.00 for such missed appointments that are not given 24 hours notice and I agree to pay this fee.

SIGNATURE (X) ____ **DATE** ____________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _________________________________ DOB: ____________________

I acknowledge that I have reviewed the Notice of Privacy Practices of __________________.

(Please initial one of the following options and sign below.)

__________ I wish to receive a paper copy of Privacy Notice.

__________ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

__________ I acknowledge that it is the policy of ______________ to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

__________ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

____ _________________________

Signature of Patient/Guardian Date

____ ________________________

Witness (Office Staff) Date

Medical History:

Please check to indicate if you are currently experiencing any of the following conditions:

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Dizziness
- ❑ Asthma
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Fatigue
- ❑ Sleeping Difficulties
- ❑ Loss of Smell
- ❑ Allergies
- ❑ Blurred Vision
- ❑ Light Bothers Eyes
- ❑ Depression
- ❑ Nervousness
- ❑ Tension
- ❑ Cold Sweats
- ❑ Stomach Problems
- ❑ Night Pain
- ❑ Sudden Weight Loss
- ❑ Loss of Taste
- ❑ Loss of Memory
- ❑ Jaw Problems
- ❑ Constipation
- ❑ Shortness of Breath
- ❑ Bowel/Bladder Changes
- ❑ Nausea
- ❑ Cold Feet
- ❑ Chest Pain
- ❑ Fever
- ❑ Fainting

Please check to indicate if you have ever had any of the following:

- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fractures
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Other ________________________________
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Whooping Cough

❑ Coronary Artery Disease → If checked : ***OFFICE USE: CardioIQ APL - 92145 Quest Test: Y / N***

Approximate Date of last Flu vaccine:__________ ***WOMEN ONLY:*** Date of LMP:_______ ***Any possibility of pregnancy: YES / NO***

Intake of following: **Cigarettes** ___ packs/day **Alcohol** ______drinks/week **Caffeine** _________ cups/day

Exercise frequency: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

NEUROLOGICAL/ MRI / PATIENT QUESTIONNAIRE:

For any YES answer, please include details.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: ____________________

2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: ____________________

3. Do your hands or arms fall asleep regularly? NO YES
   Comment: ____________________

4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: ____________________

5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: ____________________

6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: ____________________

7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: ____________________

8. Do our legs or feet fall asleep regularly? NO YES
   Comment: ____________________

9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: ____________________

10. Do you suffer from cold hands or feet? NO YES
    Comment: ____________________

11. Do have frequent falls or find that you trip over your feet while walking? NO YES
    Comment: ____________________

12. Do you suffer from headaches? If yes, how often, how severe, what has been tried? NO YES
    Comment: ____________________

13. Medicines previously tried, dosage, duration and outcome.

☐Advil ☐Aleve ☐Tylenol ☐Steroids ☐Prescriptions for a period of ☐0-3mos, ☐3-6mos, ☐6-12 mos ☐12+mos

14. Have you tried any Physical Therapy or Acupuncture treatments before? NO YES
    If yes: When? For how long? What kind?
    ____

15. Have you had an MRI? NO YES
    If yes: When? Who ordered it? What was it ordered for?
    ____

16. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
    If yes: When? What kind? Who ordered it?
    ____

17. If you have tried any treatment or medications, did this make your problem better? NO YES
    ____

Main Complaints:

1.________________________Severity 1 – 10?_______ How Long?____________Frequency?____________

What, if anything has made the problem worse? ❑driving ❑walking ❑ working ❑bending ❑sleeping Other_________________
What, if anything, has made the problem better? ❑rest ❑ice ❑ heat ❑NSAIDS ❑pain meds Other:

2 .________________________Severity 1 – 10?_______ How Long?____________Frequency?____________

What, if anything has made the problem worse? ❑driving ❑walking ❑ working ❑bending ❑sleeping Other_________________
What, if anything, has made the problem better? ❑rest ❑ice ❑ heat ❑NSAIDS ❑pain meds Other:

3.________________________Severity 1 – 10?_______ How Long?____________Frequency?____________

What, if anything has made the problem worse? ❑driving ❑walking ❑ working ❑bending ❑sleeping Other_________________
What, if anything, has made the problem better? ❑rest ❑ice ❑ heat ❑NSAIDS ❑pain meds Other:

4.________________________Severity 1 – 10?_______ How Long?____________Frequency?____________

What, if anything has made the problem worse? ❑driving ❑walking ❑ working ❑bending ❑sleeping Other_________________
What, if anything, has made the problem better? ❑rest ❑ice ❑ heat ❑NSAIDS ❑pain meds Other:

Any other complaints?____

What have you tried doing to solve this problem that did NOT work?______________________________________

____

Have you become stressed or discouraged about handling this problem(s)?_____________________________

When your problem is at it's worst how does it make you feel? ____________________________________

When this problem is at it's worst how much older does it make you feel? _____________________________

How does this problem interfere with the following areas of your life?
Work: ____
Family: ____
Hobbies: ____
Activities: ____
Life: ____

If nothing changes regarding your heath, what are you afraid this might affect or will affect?
❑ Job/Career ❑Income ❑Marriage ❑Sleep ❑Time
❑Kids ❑Finances ❑Freedom ❑Future Abilities ❑ Quality of Life

Are there any other health conditions you're worried that this might turn into?
❑Stress ❑Weight Gain ❑Heart Disease ❑Diminished Future ❑Depression ❑Surgery ❑Arthritis ❑Cancer
❑Diabetes ❑Other:_____ ____

Do you know how this problem(s) may have started? (old injury, car accident, chronic stress, toxins, etc.)
____

How have you taken care of your health in the past?
❑ Medications ❑ Naturopathic
❑ Routine Medical ❑ Chiropractic
❑ Exercise ❑ Acupuncture
❑ Diet and Nutrition ❑ Vitamins
❑ Other:____________________________________

How did the previous methods work for you?____

Are you currently under medical care? ❑ Yes ❑ No If yes, explain ____

Please list any medications you are currently taking (**Include dosage and frequency**)__________________________

____

____

Please list any surgeries and/or hospitalizations you have had (**type & date**): ___________________________________

____

Please list any allergies: ____

Are you visiting us with the goals of:
A) Resolve my immediate health complaints and/or problem(s)
B) Lifestyle program for restored health, optimized living and longevity
C) Both
D) Other:____

Where do you picture yourself being in the next 3-5 years if this problem(s) is not taken care of? Please be specific:
____
____

What would be better without this problem(s)?
❑Diminished Stress ❑More Energy ❑Self Esteem ❑Confidence ❑Sleep ❑Work ❑Outlook ❑Family

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress? (Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether family, health, work, finances, travel, marriage or bucket list!)
____
____
____
____

What potential barriers do you foresee that would prevent these things from happening?
____
____
____

Do you feel that it is possible to eliminate or prevent these potential barriers?
____
____

What are your strengths that will help you to accomplish your goals?
____
____

Rate on a scale of 1-10 (10 being the highest)
__________How important is it to resolve your health concerns?
__________Do you feel that you are teachable or would enjoy a mentor in helping you?
__________Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

Metabolic/Endocrine Function Survey

Please circle the appropriate number "0 - 3" on all questions below.   0 as the least/never to 3 as the most/always.

Category I

Feels like bowels do not empty completely	0 1 2 3
Lower abdominal pain relief by passing stool or gas	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Diarrhea	0 1 2 3
Constipation	0 1 2 3
Hard, dry, or small stool	0 1 2 3
Coated tongue of "fuzzy" debris on tongue	0 1 2 3
Pass large amount of foul smelling gas	0 1 2 3
More than 3 bowel movements daily	0 1 2 3
Use laxatives frequently	0 1 2 3

Category II

Excessive belching, burping, or bloating	0 1 2 3
Gas immediately following a meal	0 1 2 3
Offensive breath	0 1 2 3
Difficult bowel movements	0 1 2 3
Sense of fullness during and after meals	0 1 2 3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0 1 2 3

Category III

Stomach pain, burning, or aching 1- 4 hours after eating	0 1 2 3
Do you frequently use antacids?	0 1 2 3
Feeling hungry an hour or two after eating	0 1 2 3
Heartburn when lying down or bending forward	0 1 2 3
Temporary relief from antacids, food, milk, carbonated beverages	0 1 2 3
Digestive problems subside with rest and relaxation	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0 1 2 3

Category IV

Roughage and fiber causes constipation	0 1 2 3
Indigestion and fullness lasts 2-4 hours after eating	0 1 2 3
Pain, tenderness, soreness on left side under rib cage	0 1 2 3
Excessive passage of gas	0 1 2 3
Nausea and/or vomiting	0 1 2 3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and appetite	0 1 2 3
Difficulty losing weight	0 1 2 3

Category V

Greasy or high fat foods cause distress	0 1 2 3
Lower bowel gas and or bloating several hours after eating	0 1 2 3
Bitter metallic taste in mouth, especially in the morning	0 1 2 3
Unexplained itchy skin	0 1 2 3
Yellowish cast to eyes	0 1 2 3
Stool color alternates from clay colored to normal brown	0 1 2 3
Reddened skin, especially palms	0 1 2 3
Dry or flaky skin and/or hair	0 1 2 3
History of gallbladder attacks or stones	0 1 2 3
Have you had your gallbladder removed	Yes/No

Category VI

Crave sweets during the day	0 1 2 3
Irritable if meals are missed	0 1 2 3
Depend on coffee to keep yourself going or started	0 1 2 3
Get lightheaded if meals are missed	0 1 2 3
Eating relieves fatigue	0 1 2 3
Feel shaky, jittery, tremors	0 1 2 3
Agitated, easily upset, nervous	0 1 2 3
Poor memory, forgetful	0 1 2 3
Blurred vision	0 1 2 3

Category VII

Sinus Congestion	0 1 2 3
Sinus Headaches	0 1 2 3
Wheezing	0 1 2 3
Shortness of breath	0 1 2 3
Post Nasal Drip	0 1 2 3
Sore throat	0 1 2 3
Snoring at night	0 1 2 3
Seasonal Allergies	0 1 2 3
Hoarse voice	0 1 2 3

Category VIII

Wake up during the night, #_______?	0 1 2 3
Crave salt	0 1 2 3
Slow starter in the morning	0 1 2 3
Afternoon fatigue	0 1 2 3
Dizziness when standing up quickly	0 1 2 3
Afternoon headaches	0 1 2 3
Headaches with exertion or stress	0 1 2 3
Weak nails	0 1 2 3

Category IX

Cannot fall asleep	0 1 2 3
Perspire easily	0 1 2 3
Under high amounts of stress	0 1 2 3
Weight gain when under stress	0 1 2 3
Wake up tired even after 6 or more hours of sleep	0 1 2 3
Excessive perspiration or perspiration with little or no activity	0 1 2 3

Category X

Tired, sluggish	0 1 2 3
Feel cold – hands, feet, all over	0 1 2 3
Require excessive amounts of sleep to function properly	0 1 2 3
Gain weight easily	0 1 2 3
Difficult, infrequent bowel movements	0 1 2 3
Depression, lack of motivation	0 1 2 3
Morning headaches that wear off as the day progresses	0 1 2 3
Outer third of eyebrow thins	0 1 2 3
Thinning of hair on scalp, face or genitals	0 1 2 3
Dryness of skin and/or scalp	0 1 2 3
Mental sluggishness	0 1 2 3

Category XI

Heart palpations	0 1 2 3
Inward trembling	0 1 2 3
Increased pulse even at rest	0 1 2 3
Nervous and emotional	0 1 2 3
Insomnia	0 1 2 3
Night sweats	0 1 2 3
Difficulty gaining weight	0 1 2 3

Category XII

Diminished sex drive	0 1 2 3
Menstrual disorders or lack of menstruation	0 1 2 3
Increased ability to eat sugars without symptoms	0 1 2 3

Category XIII

Hive/Rashes/Urticaria (circle)	0 1 2 3
Skin itchiness	0 1 2 3
Psoriasis	0 1 2 3
Eczema	0 1 2 3

Category XIV (Males Only)

Urination difficulty or dribbling	0 1 2 3
Urination frequent	0 1 2 3
Pain inside of legs or heels	0 1 2 3
Feeling of incomplete bowel evacuation	0 1 2 3
Leg nervousness at night	0 1 2 3

Category XV(Males Only)

Decrease in libido	0 1 2 3
Decrease in spontaneous morning erections	0 1 2 3
Decrease in fullness of erections	0 1 2 3
Difficulty in maintain morning erections	0 1 2 3
Spells of mental fatigue	0 1 2 3
Inability to concentrate	0 1 2 3
Episodes of depression	0 1 2 3
Muscle soreness	0 1 2 3
Decrease in physical stamina	0 1 2 3
Unexplained weight gain	0 1 2 3
Increase in fat distribution around chest and hips	0 1 2 3
Sweating attacks	0 1 2 3
More emotional than in the past	0 1 2 3

Category XVI (Females Only)

Are you peri-menopausal	Yes No
Alternating menstrual cycle lengths	Yes No
Extended menstrual cycle, greater than 32 days	Yes No
Shortened menses, less than every 24 days	Yes No
Pain and cramping during periods	0 1 2 3
Scanty blood flow	0 1 2 3
Heavy blood flow	0 1 2 3
Breast pain and swelling during menses	0 1 2 3
Pelvic pain during menses	0 1 2 3
Irritable and depressed during menses	0 1 2 3
Acne break outs	0 1 2 3
Facial hair growth	0 1 2 3
Hair loss/thinning	0 1 2 3

Category XVII (Females Only)

How many years have you been menopausal? ______

Since menopause, do you ever have uterine bleeding?	Yes No
Hot flashes	0 1 2 3
Mental fogginess	0 1 2 3
Disinterest in sex	0 1 2 3
Mood swings	0 1 2 3
Depression	0 1 2 3
Painful intercourse	0 1 2 3
Shrinking breasts	0 1 2 3
Facial hair growth	0 1 2 3
Acne	0 1 2 3
Increased vaginal pain, dryness or itching	0 1 2 3

Medical Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not cometo the attention of the physician. I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request. I understand that my therapy may include recommendations for the following procedures: **Trigger Point Injections** are a specific type of local injection that your physician can use to treat local areas of muscle pain and spasm. Trigger point injections can help break the cycle of pain in your back and neck and help restore normal muscle function and motion. **SI Injections** are primarily therapeutic injections. These injections eliminate pain temporarily by filling the SI joint with an anesthetic medication that numbs the joint, the ligaments, and joint capsule around the SI joint. **Knee Injections** can be utilized to relieve pain and decrease inflammation to the knee joint. **Hyaluronic Acid (HA)** Joint Fluid Therapy, also called a viscosupplement, is a nonsurgical, nonpharmacological therapy for knee osteoarthritis. HA therapy can help relieve pain, improve mobility and get you back to your normal activities. HA therapy contains highly purified sodium hyaluronate, also known as hyaluronan or hyaluronic acid. Hyaluronan is a natural substance found in joint cartilage and in the fluid that fills the joints, synovial fluid. Hyaluronan acts like a lubricant and shock absorber in synovial fluid of a healthy joint. (***Please notify us if you have an allergy to eggs before receiving this injection)*** **Shoulder Injections** in the shoulder joint are necessary for therapeutic reasons in the course of treatment for shoulder pain. **Hip/IT Band Joint Injections** If this area experiences arthritis, injury or mechanical stress, one may experience hip, buttock, leg or low back pain. A hip joint/bursa injection should be considered for patients with these symptoms. The injection can help relieve the pain, and decreases inflammation and improves range of motion.

Acupuncture Consent to Care

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 the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below 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, cupping, electrical stimulation, Tiu-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teasconsumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant 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 effect 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 do not expect 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 judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that 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 and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE X ____ (Date)________________________________

(Or Patient Representative) (Indicate relationship if signing for patient)