Armonía Health LLC Medical History for Community Acupuncture

Name: _____Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

Email: _____Can we add you to our email list? YES NO Occupation: _____

Gender: _____ Age: _____ DOB: ____/____/____ Weight: _____ Referred to us by? _____

Name & contact number in case of emergency: _____

Who is your medical doctor? _____ Date of last visit: _____ Reason: _____

Have you received acupuncture/Chinese herbs in the past? _____ Date: _____ Reason: _____

Medications you are currently taking: _____

Supplements/Herbs you are currently taking: _____

Previous accidents, falls and/or surgery, with their dates: _____

_____

Major Complaint

What is your primary reason for this visit? _____

_____

Have you received treatment for this? If so, what? _____ Did it help? _____

CIRCLE any symptoms or illnesses you have currently, **CHECK** any you have had in the past:

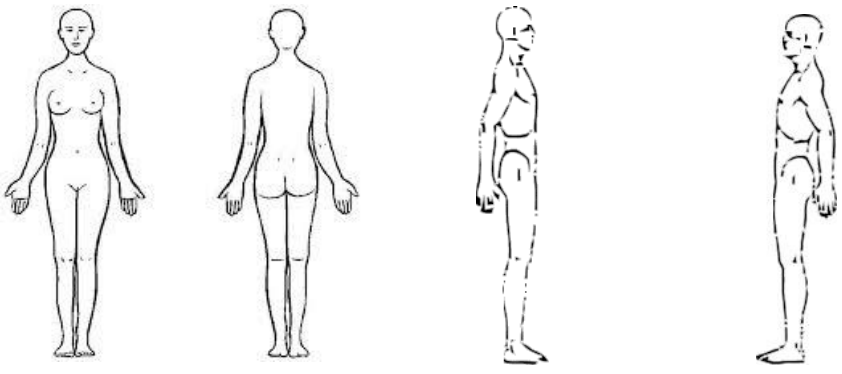
AIDS/HIV	Depression/Anxiety	Hepatitis B/C
Allergies	Diabetes	Indigestion/Acid Reflux
Alcoholism	Ear/Nose/Throat	Insomnia
Arthritis	Epilepsy	Low energy
Asthma	Fertility issues	Poor memory/concentration
Back problems	Menstrual/Hormonal issues	Tuberculosis
Blood pressure (high/low)	Gastrointestinal issues	Vertigo
Cancer	Headache/Migraine	Venereal disease
Cholesterol high	Heart disease	

Smoke? _____ Drink alcohol? _____ Caffeine? _____

List any other conditions or comments you'd like for us to know: _____

_____

Circle the areas that currently bother you



ARMONIA HEALTH LLC Community Acupuncture Policies and Consent to treat:

Our rates, payable in cash, check or credit card (we do accept Health Savings Accounts/Flex Accounts for acupuncture):

Initial Community Acupuncture session: $55

Follow up Community Acupuncture session: $40-60 ($45 minimum for credit card)

If you cannot make it to your session, please give us 24 hours advance notice.
If you miss a session without 24 hour advance notice, you will be charged $40.

I, the undersigned, hereby consent to receive acupuncture treatment from Austin Dixon or Li-Lan Hsiang Weiss. I understand that I am receiving acupuncture in a group setting (community acupuncture) and my initial consultation will be in private. Follow up sessions may be with a different acupuncturist depending on my treatment plan and appointment availability. I consent to Armonia Health LLC's acupuncturists communicating about my treatments with each other.

I am fully aware that the acupuncture needles are sterile and disposable and that no needle used to treat me has ever been used on another person.

I fully understand that there is no stated or implied guarantee of success or effectiveness of a specific treatment or series of treatments.

I understand that complications may result from acupuncture treatment. Among these possible complications are: bruising, fainting, numbness, weakness, nausea, hematoma, infection, burns, pain and discomfort, pneumothorax, and aggravation of present symptoms 24-48 hours after my session. I will communicate any concerns from my session with my acupuncturist or Armonia Health LLC's staff.

I understand that acupuncture and Chinese medicine is not a substitute for standard Western medicine, that certain health disorders may require allopathic diagnosis and treatment, and that I am free to seek allopathic medical advice and treatment at any time, either in lieu of, or concurrently with acupuncture treatment.

I understand I can communicate with the acupuncturist during my treatment if I experience discomforts.

I understand I am to let the acupuncturist know if I am or think I may be pregnant.

I fully realize that I may withdraw from my treatment at any time.

I understand and agree to hold harmless, to indemnify and protect against court action the individual therapist as well as the management of this clinic, in the event of accidental injury on these premises.

Name (please print):_____

Signature:_____ Date:_____

Parent or Guardian Signature

I, the parent or guardian of the above named minor, hereby consent to all the above terms and conditions implied in the above document and hereby give permission for my minor child to undergo acupuncture treatments for the purposes and considerations above expressed.

Parent/Guardian Signature:_____ Date:_____

Licensed Practitioner Signature: _____ Date: _____