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PLEASE PRINT

First Name _____ MI _____ Last Name _____

Male ___ Female ___ Marital Status ___ Date of Birth ___/___/___ Social Security # _____

Street Address _____ City _____ State/ZIP _____

Home Phone _____ Alternate Phone _____

Emergency Contact _____ Emergency Contact Phone _____

Email Address _____ Employer _____

Insurance Carrier _____ Does your insurance cover acupuncture? Yes ___ No ___

How did you hear about us? _____

MAIN HEALTH COMPLAINT(S) _____

Please list medications that you take _____

Please list previous surgeries _____

Do you have, or have you ever had, the following?

<input type="checkbox"/>	Allergic Rhinitis	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Hyperthyroidism	<input type="checkbox"/>	Pain – hips/pelvis
<input type="checkbox"/>	Angina	<input type="checkbox"/>	Difficulty Walking	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>	Pain – jaw
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Digestion Problems	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	Pain – joint
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	Pain – knee
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Dysmenorrhea	<input type="checkbox"/>	Infertility, female	<input type="checkbox"/>	Pain – lumbar
<input type="checkbox"/>	Backache	<input type="checkbox"/>	Earache	<input type="checkbox"/>	Infertility, male	<input type="checkbox"/>	Pain – neck
<input type="checkbox"/>	Bladder problems	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	Pain – rib
<input type="checkbox"/>	Bronchial Cough	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	Pain – sciatica
<input type="checkbox"/>	Bulging Disc	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Low Energy	<input type="checkbox"/>	Pain – shoulder
<input type="checkbox"/>	Carpal Tunnel	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	Pain – thoracic spine
<input type="checkbox"/>	Cellulitis	<input type="checkbox"/>	Fibrositis	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	Pain – thumb
<input type="checkbox"/>	Circulation Problem	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	Muscle Spasm	<input type="checkbox"/>	Pain – wrist
<input type="checkbox"/>	Colitis	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	PMS
<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Headache	<input type="checkbox"/>	Pain – abdomen	<input type="checkbox"/>	Polyuria
<input type="checkbox"/>	Coronary Art Disease	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	Pain – ankle/foot	<input type="checkbox"/>	Renal Failure
<input type="checkbox"/>	Cyclic Vomiting	<input type="checkbox"/>	Herniated Disc	<input type="checkbox"/>	Pain – arm/leg	<input type="checkbox"/>	Scoliosis
<input type="checkbox"/>	Cystitis	<input type="checkbox"/>	Herpes Simplex I	<input type="checkbox"/>	Pain – cervical spine	<input type="checkbox"/>	Spinal Stenosis
<input type="checkbox"/>	Degen Cerv	<input type="checkbox"/>	Herpes Simplex II	<input type="checkbox"/>	Pain – chest	<input type="checkbox"/>	Spondylosis
<input type="checkbox"/>	Degen Thor/Lum	<input type="checkbox"/>	Herpes Zoster	<input type="checkbox"/>	Pain – coccyx	<input type="checkbox"/>	Swollen Glands
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Hyperlipidemia	<input type="checkbox"/>	Pain – elbow	<input type="checkbox"/>	Tension
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Pain – head	<input type="checkbox"/>	Whiplash Injury

Doctor's Notes _____

Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture and/or other procedures within the scope of the practice of acupuncture, Traditional Chinese medicine (TCM), and Oriental Medicine on me (or the patient for whom I am legally responsible) by Dr. Jason Tsai, A.P., D.O.M. or other practitioners and their corresponding expertise at Advanced Acupuncture / Acupuncture Pain Control Center / Spinal and Wellness Center.

I understand that the methods of treatment may include, but are not limited to, acupuncture (with or without electrical stimulation), laser acupuncture, electromagnetic vibration, cupping, moxibustion, Oriental (*tui na*) massage, and herbs and/or nutritional supplements (including homeopathic remedies) that promote health and well-being.

I understand that acupuncture is generally a safe method of treatment that may have some temporary side effects, such as minor bruising, soreness, or tingling near the treatment sites(s). Dizziness, fainting, or a flare-up of symptoms can last a few days. Bruising is a common side-effect of cupping. Fainting can most easily be avoided if the patient takes care not to come to treatment when s/he is extremely exhausted, tired, or hungry, and if the patient remains motionless during treatment. Dizziness can be most easily avoided when the patient relaxes and rises slowly following treatment.

With sterile, disposable needles there is no risk of AIDS or hepatitis transmission. Unusual risks of acupuncture that are extremely rare include nerve damage and numbness near or at the site of penetration.

While this document describes some risks of treatment, other side effects can occur, and depend upon the individual. Although potent, the herbs and nutritional supplements that may be prescribed in this office are traditionally considered safe in the practice of Oriental Medicine. Some may be toxic in large, non-prescribed doses. I understand that some herbs may be inappropriate during pregnancy and agree to notify the acupuncturist and/or any member of the clinical staff if pregnancy occurs unexpectedly. Some possible side effects of taking herbs are nausea, gas, stomach discomfort, headache, diarrhea and constipation.

I agree to inform the Practitioner if I have a pacemaker, cardiac condition, bleeding disorder, history of seizures, or may be pregnant. Patients who take blood-thinning drugs (e.g., Coumadin/wafarin) must inform the acupuncture physician or other clinical staff due to the increased risk of bleeding.

I do not expect the acupuncture practitioner to be able to anticipate and explain all the possible risks and complications of the treatment and wish to rely upon the practitioner to exercise judgment during the course of treatment, which, based on the facts known, is in my best interest. I understand that alternatives to acupuncture treatment exist, and the prognosis for the treatment of my condition depends upon my actual condition, the duration and frequency of treatment, and my responsiveness to both the treatment and the treatment plan. I understand that results are not guaranteed.

I understand that the acupuncture practitioner and/or clinical 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. The *Notice of Privacy Practices* is clearly posted in the office and I may receive a copy upon request.

By voluntarily signing below, I acknowledge that I have read or have had read to me the above "Informed Consent for Acupuncture Treatment," and have been told about the risks and benefits of acupuncture and other treatments and procedures, and have had an opportunity to ask questions. Finally, I intend this consent to cover the entire course of treatments for my condition(s) and for any future condition(s) for which I seek treatment from Dr. Jason Tsai and/or Advanced Acupuncture and/or Acupuncture Pain Control Center and/or Spinal and Wellness Center and/or any practitioners working under the auspices of any of the above-referenced practices.

Patient's Name (Printed): _____

Signature: _____ Date: ____/____/____
 Self Parent Legal Guardian