TITUSVILLE
ACUPUNCTURE
WELLNESS CENTER

Welcome to Titusville Acupuncture Wellness Center.

We are honored that you have chosen us to be a 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

Name:_____ **Today's Date:**_____

Current Address: _____

City:_____ **State:**_____ **Zip:**_____

Birthdate:_____ **Email:** _____

Home Phone : _____ **Cell Phone:**_____

How did you hear about our office?

_____

Have you received acupuncture before? Y N

Did you receive a copy of our Notice of Privacy Practices Y N

Which of the following methods may we contact you? Please circle all that apply
Home Phone Cell Phone Text Message Email

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 _____
_____
_____

Patient/Guardian Signature _____

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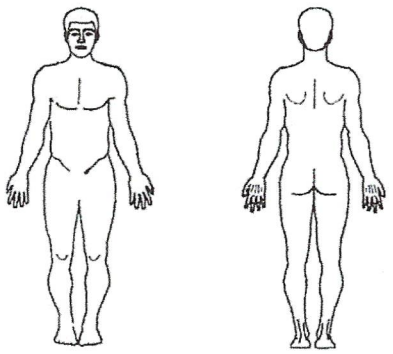
Today's Date: _____

Name: _____ **Birthdate:**_____

Please complete the following questions.

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



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

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 past week, how much has your pain or 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 pratitioner 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 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 that the need for communication with all 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 Medicine. I understand that I may stop treatments 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, and/or the the application of heat to regulate and balance Qi (body's energy), improve organ function and improve health.

I acknowledge that, although rare, certain side effects may result from Acupuncture, heat therapy and Chinese Herbal Medicine. These may include minor bruising, minor bleeding, some pain, numbness, and/or tinging at the site of the needle insertion, infection (very rare - the clinic uses sterile, single use, disposable needles, maintains a clean and safe environment, and utilized Universal Precautions). Other side effects which may occur include dizziness and fainting. 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. Potential side effects will be addressed on a case by case basis.

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

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 the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had the opportunity to ask questions. 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 _____

If we are submitting claims for reimbursement to your insurance company or government agency, please read and sign below.

Assignment of Benefits: An arrangement by which a patient requests that their health benefit payments be made directly to a provider or facility.

I authorize the release of any medical or other information necessary to process claims on my behalf. I also request the payments of these claims to be paid to Titusville Acupuncture Wellness Center and/or Eric Hunstad, L.Ac. who will be accepting this assignment.

Patient Signature _____ Date _____