Welcome to Acupuncture for All.

We are delighted that you have decided to get acupuncture with us.

About acupuncture

Acupuncture is very old. While there are many theories, we don't *really know* why it works. We just know it does work. We believe that people should be able to try it, and decide for themselves if they want to use it as part of their health care. We know that improvement of symptoms through acupuncture is a process. The effect of acupuncture is cumulative. Depending on the onset and severity of particular health conditions, you may find relief after the first treatment, or after several continuous treatments. Most people start to notice changes after 4 to 6 treatments. Acupuncture works best when you can commit to a plan.

Being Treated For:	**Treatment Frequency**	
Very Severe Discomfort	Daily until change in condition	For several days
Serious Discomfort	Every other day until change	A week or two
Moderate Discomfort	Twice weekly until change	Over several weeks
Working on a Health Issue	Twice weekly until change	Over several weeks
Ongoing Episodic Condition	Weekly + as needed	Over a few months
Support for chronic issues	Weekly	Ongoing or as needed
General Health	Weekly to monthly	Ongoing or as needed

While in the treatment room please observe the following:

Make sure you have eaten before coming for treatment.
Turn off your cell phone before entering the clinic and please speak quietly in the treatment room.
Remain seated while your needles are in.
Wait for the acupuncturist to remove your needles and dispose of any needles which may have become dislodged.
Wear shoes when walking through the treatment room.
Thank you for your cooperation.

We are available to listen to any feedback you may have about AFA.

Thank you for coming to Acupuncture for All.

We are happy you are here and hope you enjoy the clinic

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ACUPUNCTURE for ALL

PATIENT REGISTRATION and HEALTH HISTORY

Name: _____

Address:_____City:_____State:_____Zip:_____

Phone Number :(cell/home/other) _____

E-mail:_____

Age:_____Date of birth_____

Date of last complete medical exam?_____Do you have a local MD? _____

Please list any current medications you are taking._____

Do you have a bleeding disorder?_____ Are you taking any blood thinners? _____
De you have diabetes?_____Are you pregnant?_____Do you have a pacemaker? _____
Please list major surgeries, accidents or illnesses._____
_____

Please list the main reasons for today's visit:

1.)_____

2.) _____

When did the symptoms start?

1.) _____

2.) _____

What makes the condition better? What makes the condition worse? What treatments have you tried?

1.) _____ _____ _____
2.) _____ _____ _____

How is your digestion? _____

How is your sleep? _____

How is your energy?_____

Personal Health History

Please ***circle*** any of the following ***that apply you*.**
Please mark with an **"F"** any that apply to **family members**.

Heart disease_____ Heart attack_____ Stroke_____ High Blood Pressure_____

Liver disease_____ Kidney disease_____ Cancer_____ Diabetes_____

Current Symptoms

Please mark if any of the following apply currently or in the last six months have troubled you.

Digestive issues: Constipation, diarrhea, pain, poor digestion, acid reflux, ulcers, IBS, low or excessive appetite, cravings, gas, bloating, fatigue after eating, other.

Respiratory issues: Shortness of breath, cough, wheezing, frequent colds, congestion, asthma, allergies, other.

Chest pain / tightness / pressure

Rapid or irregular heart beat

Dizziness or vertigo

Headaches / migraines

Urinary issues

OBGYN issues

Reproductive issues

Cravings

Feeling hot /cold

Swelling

Night sweats or spontaneous sweating

Insomnia

Stress

Depression

Anxiety

PTSD

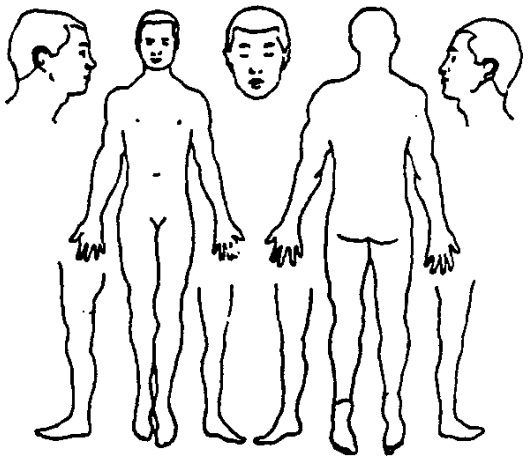
Any other concerns?

Pain, weakness, numbness, tingling, swelling, or lack of mobility in your muscles, joints, bones?

Neck / Shoulder / Back - Upper back – Middle back - Lower back

Arms / legs / hands / feet

Hips / knees /ankles / elbows / wrists



PLEASE let us know how your condition may have changed when you return for treatments.

Also, **it is important** to tell us if you have an acute condition such as a headache, a cold or the flu or other infectious conditions so we can adjust your treatment.

AFA Informed Consent to Acupuncture Treatment

I, the undersigned, hereby request and consent to acupuncture treatment and/or other procedures within the scope of the practice of Oriental Medicine. I am hereby informed that the treatment methods are all generally safe, but there may be some side effects or risks.

Acupuncture involves the insertion of small solid needles into particular points on the body. There are some risks to treatment, including: bruising of the skin and/or slight bleeding, weakness, fainting and, aggravation of symptoms existing prior to acupuncture treatment. There is little to no risk of infection when all needles are sterile. AFA uses only one-time use, sterile disposable needles. We do not reuse needles, even at different areas of the body for the same person.

Results are not guaranteed. Acupuncture is a process, and results will vary.

We do not provide primary care, or Western (allopathic) medical care. Please see your medical doctor for those services and for routine check-ups. If you are pregnant, have a bleeding disorder, pacemaker, high blood pressure, local infection, or have been prescribed anticoagulant medications, by signing below you state that you have informed your acupuncturist of such conditions, and agree to inform your acupuncturist as your condition changes.

I will ask my acupuncturist if I have questions about my treatment or about the risks and benefits of acupuncture.

With this knowledge, I voluntarily consent to the above procedures.

Name_____

Signature_____

Date_____

Signature of Guardian required if patient is less than 18 years old

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Acupuncture for All Privacy Policy

In accordance with HIPAA (Health Insurance Portability Assurance Act) regulation and Arizona law, Acupuncture for All takes your right to privacy seriously. We do not disclose any personal, health, financial, or any other information about you, or the services we provide to you to any third parties without your request or permission. This includes online services we provide, including access to your appointment information, user - ID, or password.

Patient's Name_____

Signature_____

Date _____

Acupuncture for All Financial Policy

Fee Schedule:

- $30-$60 per treatment
- There is an additional $20 fee for the first consultation.
- We do not require income verification. You decide what you to pay at each visit. At any time you may change the amount that you pay.
- Payment is expected at the time of your visit.
- We accept checks, cash, Visa, Discover, and MasterCard.
- We are not able to directly bill any insurance plans or other third parties, but will happily provide you a receipt to submit for reimbursement. Just ask.

We reserve an appointment time for you and ask that you call us if you cannot keep your appointment. In consideration, we ask that you give us at least 12 hours notice in advance of an appointment that you will not be able to keep. We understand there are times you may need to reschedule at the last minute, and we understand.

Appointments that are canceled with less than 12 hours notice, or are missed altogether without notification, will be charged a $15.00 fee payable at the next visit.

By signing below you are stating that you agree to the above policy:

Patient Name:_____

Signature: _____

Date_____