

Northfield

Acupuncture & Alternative Medicine Clinic

“Where Natural Healing Begins”

Acupuncture Patient Intake/Health History Form

Name: _____ Email: _____

Home:(_____) Work:(_____) Cell:(_____)

Address: _____ City _____ State: _____ Postal Code: _____

Date of birth: ____ / ____ / ____ Age: _____ Height: _____ First time for Acupuncture: YES / NO
M D Y

Family Physician: _____ Address: _____

Who can we thank for referring you here? _____

Reason for Visit: _____

Medical Information

1. Are you currently receiving any therapy from another health care practitioner?

- | | |
|---|--|
| <input type="checkbox"/> Medical Doctor | <input type="checkbox"/> Massage Therapist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Physiotherapist |
| <input type="checkbox"/> Naturopath | <input type="checkbox"/> Dietitian |

2. Are you taking any medications? YES / NO. If “YES”, what?

Medication/ Supplements	Reason	Date Began	Dose	Helps Yes or No

3. Are you pregnant? YES / NO. If “YES”, what trimester? _____

4. Lifestyle Choices / Habits (please check all that applies to you):

- Exercise Alcohol/Drugs Caffeine Smoking Other _____

5. Surgeries YES / NO (if “YES”, please indicate nature and date of procedure) _____

6. Accidents YES / NO (if "YES", please indicate the date of accident) _

7. Current Level of Stress Low Moderate High

8. General Health Status:

Excellent Good Fair Poor

Please check if you are experiencing or have experienced any conditions below:

<p>Regional Areas of Concern</p> <ul style="list-style-type: none"> <input type="checkbox"/> Neck/ Head/ Face <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/> Chest/ Abdomen <input type="checkbox"/> Spine <input type="checkbox"/> Pelvis <input type="checkbox"/> Hip <input type="checkbox"/> Leg <input type="checkbox"/> Hands/ Feet <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Muscle soreness <input type="checkbox"/> Pins, plate, implants <input type="checkbox"/> Artificial joints <input type="checkbox"/> Cosmetic implants <input type="checkbox"/> Joint problems (arthritis, etc) <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Other <p>What? _____</p> <p>Neurological</p> <ul style="list-style-type: none"> <input type="checkbox"/> Epilepsy <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Loss of sensation <input type="checkbox"/> Neuritis <input type="checkbox"/> Other <p>What? _____</p>	<p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chronic cough <input type="checkbox"/> Bronchitis <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Other <p>What? _____</p> <p>Infectious Diseases</p> <ul style="list-style-type: none"> <input type="checkbox"/> Infectious skin conditions <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV <input type="checkbox"/> Other <p>What? _____</p> <p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Prolonged constipation <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Chronic abdominal discomfort <input type="checkbox"/> Diarrhea <input type="checkbox"/> Other <p>What? _____</p>	<p>Cardiovascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Chronic Congestive Heart Failure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Myocardial Infarction <input type="checkbox"/> Phlebitis <input type="checkbox"/> Cerebrovascular accident (Stroke) <input type="checkbox"/> Presence of a pace maker or similar device <input type="checkbox"/> Hemophilia <input type="checkbox"/> General circulatory disorder <input type="checkbox"/> Varicose veins <input type="checkbox"/> Dizziness <input type="checkbox"/> Chest pain <input type="checkbox"/> Other <p>What? _____</p> <p>Renal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Kidney stones <input type="checkbox"/> Dialysis <input type="checkbox"/> Nephritis <input type="checkbox"/> Other <p>What? _____</p>	<p>Allergies</p> <ul style="list-style-type: none"> <input type="checkbox"/> Known allergies or Hypersensitivities <p>What? _____</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Skin irritations <p>Medical Conditions</p> <ul style="list-style-type: none"> <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Skin conditions <p>What? _____</p> <p>Reproductive</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pregnancy <input type="checkbox"/> Endometriosis <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Prostate condition <p>Special Senses</p> <ul style="list-style-type: none"> <input type="checkbox"/> Vision Problems <input type="checkbox"/> Vision loss <input type="checkbox"/> Hearing loss <input type="checkbox"/> Altered taste <input type="checkbox"/> Altered smell
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Northfield Acupuncture & Alternative Medicine Clinic, Inc.

619 E. 6th St.
Texarkana, AR 71854
(870)772-8622

CONSENT FOR ORIENTAL MEDICINE

The practice of oriental medicine in Arkansas is a distinct system of primary health care with the goal of prevention, cure, or correction of any illness, injury pain or other physical or mental condition by controlling and regulating the flow and balance of energy and functioning of the person to restore and maintain health. Oriental medicine includes all traditional and modern diagnostic, prescriptive and therapeutic methods utilized by practitioners of acupuncture and oriental medicine worldwide. The scope of practice of Doctors of Oriental Medicine shall include but is not limited to:

1. Evaluation and management services;
2. Examination and diagnostic testing;
3. The ordering of radiological, laboratory or other diagnostic tests;
4. The procedures of acupuncture, injection therapy and other related procedures;
5. The stimulation of points or areas of the body using needles, heat, cold, light, lasers, sound, vibration, magnetism, electricity, bleeding, suction, pressure, or other devices or means;
6. Physical medicine modalities and procedures;
7. Therapeutic exercises, breathing techniques, meditation, and the use of biofeedback and other devices that utilize color, light, sound, electromagnetic energy and other means therapeutically;
8. Dietary and nutritional counseling and the administration of food, beverages and dietary supplements therapeutically;
9. The prescription or administration of any herbal medicine, homeopathic medicine, or substances such as vitamins, minerals, enzymes, glandular, amino acids and nutritional or dietary supplements; and
10. Counseling regarding physical, emotional and spiritual balance in lifestyle.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: Side effects may include, but are not limited to the following: pain following treatment in insertion area, minor bruising, infection, needle sickness, broken needle, temporary discoloration of the skin, aggravation of symptoms existing prior to the treatment.

Patients with bleeding disorders, pacemakers, seizure disorders, or women who are currently pregnant, please notify the Doctor of Oriental Medicine.

Potential benefits: Relief of presenting symptoms, improved general health, elimination of the presenting problem, reduction of pain and associated symptoms.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dan L. Martin, D.O.M. regarding cure or improvement of my condition. I hereby release Dan L. Martin, D.O.M. from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate care.

I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Signature of Patient or Guardian _____

Date _____

Welcome to...

Northfield

Acupuncture & Alternative Medicine Clinic

We are excited that you have chosen Dan Martin, O.M.D., D.O.M. as your health care practitioner. This letter is designed to help you understand more about Northfield Acupuncture and Alternative Medicine Clinic.

The office is open for appointments Tuesday, Wednesday, Thursday 9am to 5pm and Saturday 9am to 3 pm. Please make your appointment in advance if possible. If you are unable to keep your scheduled appointment, please call at least 24 hours in advance to reschedule for a more convenient time. Walk-ins are welcome, although scheduled appointments will be given priority.

At Northfield Clinic, your health is our top priority. Cooperation and consistency on your part will speed you down the road to better health. All new patient paperwork, surveys, and questionnaires are required to be filled out prior to seeing the doctor. The information they provide us is very important. Please do not “over think” your answers on the questionnaires and surveys. There is no wrong or right answer, only what best describes your situation.

Your treatment may require multiple visits to get you to where you need to be. For example, if you are receiving acupuncture for back pain or neck pain, the number of treatments required can vary from 5 to 20. IV therapy can be up to and above 20 treatments. Long gaps between treatments can set back your recovery and extend the number of treatments required. These are examples, and your case will vary depending upon your condition. Following the recommended dietary, supplement, exercise, and rest regimens will also increase the effectiveness of your treatments.

Payment is due when services are rendered. If you have questions about the price of your treatment, please ask the office manager.

Good health takes time, commitment and cooperation. If you feel that your treatments are working, tell us! If you feel that your treatments are not working or if you do not feel that you are healing as you anticipated, let us know. We do not know how you feel or if your treatments are working unless you inform us. Our ability to treat you depends on your input. We are a team, and your health is our long-term goal. If you have any questions, feel free to ask us.

F.D.A STATEMENT

The statements and opinions expressed by Dan Martin O.M.D., D.O.M. of Northfield Acupuncture and Alternative Medicine Clinic. Written, audio, video and other formats have not been evaluated by the Food and Drug Administration (FDA).

Information and/or treatments received from Dan Martin O.M.D., D.O.M. / Northfield Acupuncture and Alternative Medicine Clinic are not approved by the Food and Drug Administration (FDA) to diagnose, treat, cure or prevent any disease.

I have read and understand the above policies. I understand that my health will take time and commitment on my part.

Signed: _____ Date: _____