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ACUPUNCTURE QUESTIONNAIRE AND INFORMED CONSENT

Please answer the questions, read the statements that relate to  
acupuncture practice at this office, and sign below.  
(Use back of form if you need more space)

NAME: \_\_\_\_\_ DAY PHONE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_  
EMPLOYED BY: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_  
EMERGENCY CONTACT: (NAME) \_\_\_\_\_ (PHONE) \_\_\_\_\_

PLEASE FILL OUT THE FOLLOWING COMPLETELY:

YES NO

1. Have you had a recent surgery, injury/accident, or illness?  
(If yes, please state date and type.) \_\_\_\_\_ YES NO
2. Do you have or have you had any of the following conditions?
- |                           | YES | NO  |                            | YES | NO  |
|---------------------------|-----|-----|----------------------------|-----|-----|
| a. Heart Problems         | ___ | ___ | g. Allergies               | ___ | ___ |
| b. High Blood Pressure    | ___ | ___ | h. Kidney Problems         | ___ | ___ |
| c. Diabetes               | ___ | ___ | i. Liver Conditions        | ___ | ___ |
| d. Arthritis              | ___ | ___ | j. Varicose Veins          | ___ | ___ |
| e. Cancer                 | ___ | ___ | k. Contagious Skin Disease | ___ | ___ |
| f. Other (Describe) _____ | ___ | ___ |                            | ___ | ___ |
3. Are you taking any drugs or medications? If yes, list on reverse \_\_\_\_\_ YES NO
4. Do you wear contact lenses? \_\_\_\_\_ YES NO
5. Are you pregnant? \_\_\_\_\_ YES NO
6. Have you ever had acupuncture? \_\_\_\_\_ YES NO
7. Are you experiencing any soreness in a specific area? \_\_\_\_\_ YES NO
8. Have you ever been exposed to hepatitis? \_\_\_\_\_ YES NO
9. Have you ever had hepatitis? \_\_\_\_\_ YES NO
10. Have you ever been exposed to the HIV (AIDS) virus? \_\_\_\_\_ YES NO
11. Do you have AIDS? \_\_\_\_\_ YES NO
12. Have you recently taken blood thinners or anticoagulants? \_\_\_\_\_ YES NO
13. Are you taking aspirin on a regular or frequent basis? \_\_\_\_\_ YES NO
14. Are you taking cortisone on a regular or frequent basis? \_\_\_\_\_ YES NO
15. Do you bleed easily? \_\_\_\_\_ YES NO
16. Have you ever been told you have a heart problem? \_\_\_\_\_ YES NO
17. Do you have a pacemaker or surgical implant in your body? \_\_\_\_\_ YES NO