Patient Name _____ Date _____

Chief Complaint(s) 1 _____ 2 _____

Is your present problem due to an injury ☐ On the Job ☐ Auto Accident ☐ Personal Injury ☐ Other _____

Did your pain begin ☐ Gradually ☐ Suddenly

Is your pain ☐ Constant ☐ Intermittent

Is your pain worse when you ☐ Sit ☐ Bend ☐ Walk ☐ Lift ☐ Push ☐ Pull ☐ Other _____

Which of the following areas do you have the most pain, discomfort or restriction of motion

☐ Neck ☐ Shoulders ☐ Arms ☐ Hands ☐ Upper Back

☐ Mid Back ☐ Low Back ☐ Pelvis ☐ Hips ☐ Legs

☐ Knees ☐ Feet ☐ Other _____

Using the following chart, how would you rate your pain in percentages when you

Occasionally = 33%
Frequently = 34-66%
Constantly = 67-100%

Sit _____% of the time

Stand _____% of the time

Walk _____% of the time

Rate the severity of your pain by checking one box on the following scale

10 = Extreme Pain
1= least pain

Extreme

10
9
8
7
6
5
4
3
2
1
0

None

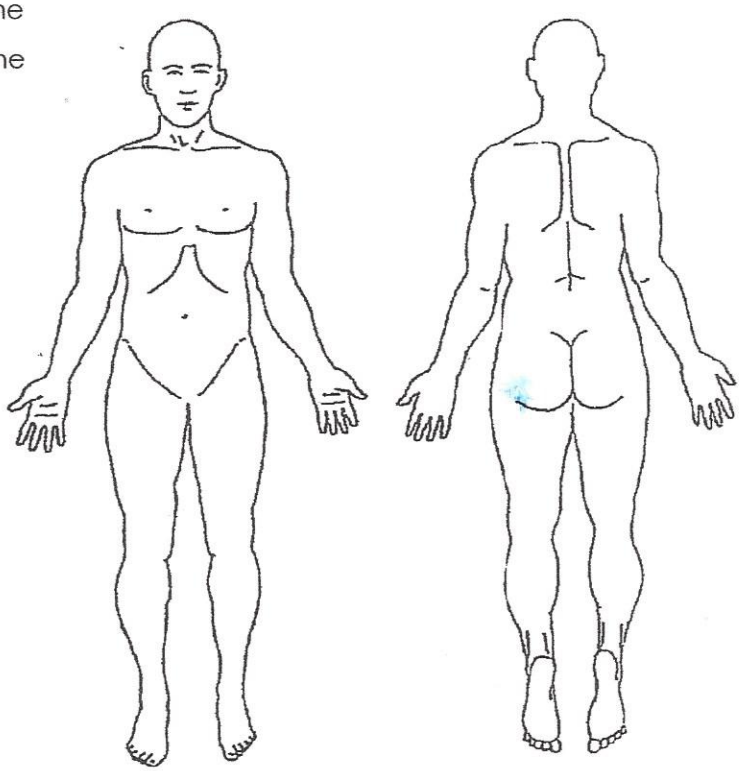
Circle the areas of pain on the figure to the right. Then indicate the type of pain using the codes below:

+++ Burning

--- Sharp

000 Stabbing

III Constant



Does your pain interfere with your ☐ Work ☐ Sleep ☐ Daily Routines

Do you feel your present condition is ☐ Temporary ☐ Permanent ☐ Not Sure

List as additional comments you wish to make regarding your condition _____

_____

_____

Patient Signature _____

Acupuncture by Suzanne

INFORMED CONSENT

Every type of healthcare is associated with some risk of a potential problem. We want you to be informed about the potential problems with the various alternative treatments we offer here at Your Healthy Spine when consenting to care.

ACUPUNCTURE

Nature of Treatment: Your treatment may include acupuncture, moxibustion, cupping, electric or magnetic stimulation, acupressure, dermal friction (Gua Sha), infra-red (heat lamps), herbs, therapeutic exercises, essential oils and dietary counseling based on the fundamentals of Chinese medicine.

Purpose of Treatment: The purpose of the treatment is to resolve your complaint, i.e. the reason you are seeking treatment. Acupuncture is a health care service that is based on an Oriental system of medical theory. Diagnosis and treatment, based on these theories are used to promote health and treat organic or functional disorders.

Benefit of Treatment: Acupuncture and Oriental Medicine procedures have been used effectively to treat disease for hundreds of years. The World Health organization lists 43 conditions, which may effectively be treated by Chinese medical methods. These include muscular-skèletal injuries, digestive disorders, respiratory diseases, women's health issues, etc.

Risks of Treatment: Acupuncture and Oriental medicine have been shown to be relatively safe. However, there are some uncommon but potential risks. These potential risks may include but are not limited to: pain or discomfort during and after the insertion of a needle, "needle sickness" (dizziness, fainting, nausea), localized, minor bruising or swelling, minor burns with the use of moxa, electrical shock with electro-acupuncture, gastro-intestinal upset with the use of Chinese herbs (if this occurs, please consult with your practitioner so that your formula can be modified), possible, temporary aggravation of symptoms that existed prior to treatment, a broken needle (rare with the use of disposable needles).

Special Situations: Some herbs and acupuncture points are contra-indicated during pregnancy. Please notify us if you might be pregnant. Additionally, please inform us if you have severe bleeding disorders or if you are wearing a pacemaker or other electronic medical device.

Other problems: There may be other problems or complications that might arise other than those noted above. These other problems or complications occur so rarely, it is not possible to anticipate and/or explain them in advance of treatment.

Suzanne Bradford, L.Ac. offers various alternative healthcare options. As with any healthcare option, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you the best care, and if the results are not acceptable, we will refer you to another healthcare professional.

Payment for Services & Cancellation Policy:

All services performed by *Suzanne Bradford, L.Ac.* are to be paid for by the patient at the time of service. Twenty-four hours notice is required in the event you need to cancel or reschedule an appointment. When you schedule your acupuncture appointments you are making a commitment to your health and your well-being. Making an appointment is a time and money commitment that we make to each other. Cancelling your appointment without sufficient notice creates a loss situation for all of us. You aren't getting the health support that you need, other patients are prevented from scheduling that treatment time, and the clinic loses the

financial support that sustains it. By signing below, I understand that if I miss an appointment or fail to cancel that appointment within 24 hours of its start time, I will be charged a fee of $50.00.

INFORMED CONSENT

I do not expect the clinical staff to be able to anticipate and explain all risks and complications, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff feels at the time, based upon the facts then known, is in my best interests. I understand that it is my responsibility to give accurate information regarding my current, previous, and future health conditions as it may affect the safety and value of my treatments here. I understand that I may ask to discontinue treatments at any time while I am a patient here and that if I have any questions regarding treatments it is my responsibility to ask my practitioner. If I notice any sensations, symptoms, or feelings that concern me I will discuss them with my practitioner immediately. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I give my permission and consent to treatment with *Suzanne Bradford, L.Ac.*

Patient's Name (please print) _____

Signature _____ Date _____