Thomas Richardson, MAcOM, Dipl. OM (NCCAOM)
Extraordinary Chinese Medicine, LLC

Acupuncture Intake Form

This information is confidential Date: _____

Name: _____ Age: _____ Sex: M / F
Address:_____ Birth Date: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell: _____
E-Mail: _____

Occupation: _____
Physician: _____ Physician Phone #: _____

Referred by: _____

Have you ever had acupuncture? Y / N

What is your current complaint? _____
_____How long? _____

What other treatments have you tried? _____
_____

Medications you are currently taking:	For what conditions:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medical History (Check all that apply)

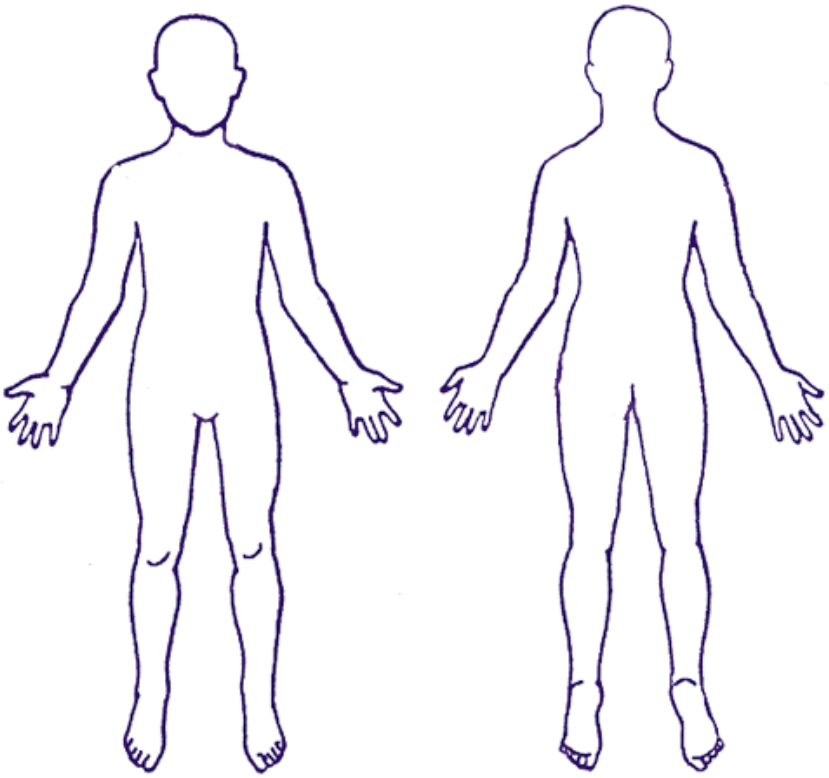
___Aids/HIV	___Alcoholism/Substance Abuse	___Colitis
___Bleed Easily	___Irritable Bowel Syndrome	___Epilepsy
___Jaundice	___Kidney Disease	___Varicose Veins
___Migraines	___Thyroid Disorder	___Tuberculosis
___Allergies	___Hepatitis A / B / C	___Polio
___Asthma	___Birth Trauma	___Seizures
___Cancer	___Herpes	___Pacemaker
___Emphysema	___Lyme Disease	___Heart Disease
___Diabetes	___Multiple Sclerosis	___High Blood Pressure

Other:_____

Are you currently taking or have you taken recently:
Coumadin, Warfarin, or any blood thinner? Yes / No
Lithium, Zoloft, Prozac, or any anti-depressant/anti-anxiety medication? Yes / No
Sleeping pills? Yes / No

Thomas Richardson, MAcOM, Dipl. OM (NCCAOM)
Extraordinary Chinese Medicine, LLC

Mark with an (X) where you are feeling any discomfort or pain.



If pain, please describe: Sharp Dull Stabbing (please circle)

What makes the pain better? (circle all that apply)
heat cold movement massage rest

Do you have any additional health conditions?_____
_____
_____
_____
_____
_____

Print Name _____

Patient Signature _____

Thomas Richardson, MAcOM, Dipl. OM (NCCAOM)
Extraordinary Chinese Medicine, LLC

Please print out this form, read it carefully, initial the first page, sign & date where indicated at the bottom of the form, and bring it with you to your first treatment. Thank you!

New Patient Information

Here are some general guidelines regarding your appointment:

1. Please eat a moderate amount of food 1 to 1½ hours before your appointment.
2. Please dress comfortably or wear loose clothing so that your arms and legs may be accessible. If we need to have access to your back or other areas that require the removal of clothes, we will drape you appropriately with a sheet.
3. Whenever possible, please arrange your schedule so you do not have to rush to or away from the clinic.
4. Please tell us if you are uncomfortable with physical touch or with discussing certain activities or parts of the body.
5. Feel free to ask any questions that may arise during your treatment. It is important that you feel informed and understand your own health!

Cancellation Policy: Cancellation confirmation must be done via phone and at least twenty-four (24) hours prior to your appointment time, or you may be charged for the appointment.

Payment for Services Rendered

Payment is due at the time of service & may be paid in cash or check.

Appointment Reminders and Health Care Information authorization

Protecting your privacy and healthcare information is fundamental in the course of our relationship. The independent practitioners and any staff member of Extraordinary Chinese Medicine, LLC may need to use your name, address and phone number to contact you with appointment reminders, to follow-up after an appointment, to provide information about your treatment alternatives, or other health-related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering device or with whoever answers the phone. Appointment reminders, cards, and other correspondence may be sent to your address. By signing this form, you are giving us authorization to contact you with these reminders and information. Please let us know in person if you would like to change your preferences.

We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. You may contact our Privacy Contact to request that these materials not be sent you.

Further, in order to provide you with quality care and to comply with certain legal requirements, we create a record of the care and services you receive at this clinic. We are committed to protecting, securing and keeping confidential your personal and medical information unless we have your written consent for its disclosure. There are instances, however, in which your personal health information may be disclosed without your expressed written consent according to the Health Insurance Portability & Accountability Act (HIPAA); these include 1) at your verbal request, 2) for default of payment, 3) as required by an agency of the government.

_____
Patient's name (please print)

_____ _____
Patient's signature Date signed

Thomas Richardson, MAcOM, Dipl. OM (NCCAOM)
Extraordinary Chinese Medicine, LLC

Informed Consent to Acupuncture and Oriental Medicine

I hereby request and consent to the performance of acupuncture, and other procedures within the scope of the practice of Oriental Medicine, on me (or the patient named below for whom I am legally responsible) by Thomas Richardson, MAcOM, Dipl. OM (NCCAOM).

I understand that methods of treatment may include, but are not limited to: acupuncture; moxibustion; cupping; gua'sha (scraping therapy); needle retention; tuina (Chinese manipulation); electrical, laser, and/or magnetic stimulation; micropuncture (mild bleeding therapy); diagnostic palpation on various areas of my body; herbal medicine; and nutritional and/or lifestyle counseling.

I understand and am informed that in the practice of Oriental Medicine, as in the practice of allopathic medicine, there are some side effects and/or risks of treatment; I understand that although these are unlikely to occur, they are possible. Some of these effects include, but are not limited to: bleeding; bruising, numbness, tingling, pain or other strong sensation at the location where a needle is inserted or radiating from that location; aggravation of current symptoms; appearance of new symptoms; general aches or dizziness. Bruising is a common side effect of gua'sha and cupping. Burns and/or scarring are a potential risk of moxibustion and cupping. Unusual risks of acupuncture include infection or nerve pain, although the acupuncturist uses sterile, single-use, disposable needles and maintains a clean and safe environment. Highly unusual risks include organ puncture, including pneumothorax (punctured lung), and spontaneous miscarriage. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I understand that I have the choice to accept or reject the proposed diagnostic procedure or treatment, or any part of it, at any time before or during the diagnosis or treatment.

The Chinese and Western herbs (which are derived from plant, animal and mineral sources) that are recommended are traditionally considered safe in the practice of herbal medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomachache, diarrhea, headache, rashes and tingling of the tongue; some possible side effects of applying topical creams, liniments, ointments and plasters are rashes, hives and tingling of the skin. I understand that some herbs may be inappropriate during pregnancy and will immediately notify the acupuncturist(s) if I know or suspect that I am pregnant. Further, I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption or application of any Chinese herbs.

I do not expect the acupuncturist(s) to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist(s) to exercise such judgment based on the known facts, during the course of my treatment, to be in my best interest. I understand that results are not guaranteed.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the benefits and risks of acupuncture treatments and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from this clinic.

_____
Patient's name (please print)

_____ _____
Patient's signature Date signed
or signature of Patient's Representative/Legal Guardian

_____ _____
Representative/Legal Guardian, if applicable (please print) Relationship or authority