Shannon Considine, M. Ac., L. Ac., Dipl. Ac.

Information and Consent to Services

Treatment Policy
I hereby *voluntarily* consent to acupuncture treatments and understand the following:

That the attending practitioner may administer any treatment or perform any service deemed advisable in my care and treatment.

That I will have the opportunity to discuss therapeutic courses with the practitioner to my satisfaction;

That I have the right to consent to or refuse any proposed treatment or course of treatment.

That each person is unique and has ultimate responsibility for his or her own healthcare. I acknowledge that I have not received any guarantees or promises as to the results or success that will be obtained from acupuncture and/or moxabustion.

Services Provided
I understand that acupuncture serves individuals with a wide range of complaints including both acute and chronic healthcare issues. I understand that I will be treated with the insertion of thin, sterilized needles and/or with moxabustion, which is an application of heat to the skin.

Risks/Possible Side Effects/Healing Response
I understand that infectious diseases are carried through the air, through physical contact, and through body fluids. I understand that my practitioner follows universally prescribed precautions and procedures (such as clean needle technique, clean room procedures, and hand washing) to prevent the spread of infectious disease.

I have read this form entirely. I have also received the Notice of Privacy Practices and the Practices Regarding Disclosure of Health Information. I am under no obligation to sign and do so of my own volition in order to pursue treatment.

Patient Name: _____
(Print)

Patient Signature:_____

Signature of parent or guardian if patient is minor:

_____

Patient Responsibilities
I understand it is my responsibility as a patient to inform my practitioner about all aspects of my health and that, as treatment progresses, to inform my practitioner of changes that occur. If I experience any pain, discomfort or possible adverse reactions or side effects, it is my responsibility to immediately notify my practitioner.

Medical Treatment
I recognize that my practitioner is not a substitute for a medical doctor and will not suggest that I discontinue medical treatment. I am free to consult a medical doctor or any other licensed practitioner at any time. I understand if there is an emergency, or a worsening or my health condition, or if a new ailment or condition arises, that I should consult a licensed physician.

Confidentiality and Exceptions
I acknowledge that I received a copy of Shannon Considine's Notice of Privacy Practices and the accompanying Practices Regarding Disclosure of Patient Health Information, which describes the practitioner's policy of respecting patient's right to privacy and the exceptions that require disclosure of confidential information.

License and/or Certification
I understand that Shannon Considine, my practitioner, has studied extensively the field of Acupuncture and Moxibustion and has earned a Master's Degree from the TAI-SOPHIA INSTITUTE, a nationally respected institution in the field. She has also obtained her license to practice from the Maryland State Board of Acupuncture, and received board certification from the NCCAOM, the National Certification Commission for Acupuncture and Oriental Medicine. I have the right to ask for copies of those licenses and certifications.

Fees and Charges
I have been informed of the fees of services and I understand that payment is due when the services are rendered.

I understand that if I need to cancel an appointment, I will notify my practitioner at least 24 hours in advance, or I am liable for a fee.

Date:_____

Date:_____

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Patient Financial Agreement

I acknowledge that I am the financially responsible party for payment of any Service, Treatment, Referral or Cancellation fees incurred by:

_____

Patient's Full Name (PRINTED)

and provided by Shannon Considine, Acupuncture Therapist, and staff if:

1) **the services provided are not covered by Patient's insurance;**
2) **the insurance information provided by the Patient is not accurate; and**
3) **patient is now or becomes uninsured.**

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Self-Payment and insurance co-pay and deductible fees are due at time of service.

Returned Check Fee $25 – for any checks returned by your bank.

Cancellation Policy – 24-hour notice required.
Appointments cancelled within 24 hours of scheduled appointment time are subject to a $50 cancellation fee payable directly by patient.

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_____

Printed Name & Address of Financially Responsible Party

_____ _____ _____

Responsible Party Signature | Relationship to Patient Self or Other (Please Describe) | Today's Date

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Patient Intake Form

Please help me provide you with a complete evaluation by taking the tiem to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

IDENTIFICATION: Date: _____

Name: _____ Gender: ❑ Female ❑ Male Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ (Home) _____ (Work) _____ (Mobile)

Date of Birth: _____ Age: _____

Single: ❑ Married: ❑ Separated: ❑ Divorced: ❑ Widowed: ❑ Partnered: ❑

Education: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact's Telephone: _____ (Home) _____ (Mobile)

Name of Physician*: _____ Physician's Telephone: _____

Physician's Address: _____

Date of Last Physician Appointment: _____ Date of Last Gynecology Exam: _____ ❑ N/A

Have you ever been treated with acupuncture and/or Chinese herbal medicine before? ❑ Yes ❑ No

*No contact will be made to the physician without your permission.

FAMILY HISTORY — Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an "X" or the date in the appropriate box(es).

	Self (date)	Mother	Father	Sibling	Spouse	Children
Cancer or Tumors						
Diabetes						
Blood or Bleeding Disorders/Anemia						
Seizures						
High Blood Pressure/Heart Disease						
Allergies						
Stroke						
Drug Abuse						
Depression or Mental Illness						
Deceased (age)						
Hepatitis						
Kidney Disorders						
Thyroid Disorders						
Musculo-Skeletal Disorder						
Blood Transfusion (if before 1985)						

PERSONAL LIFESTYLE HABITS: For each item, please indicate how much, how many, or how often. Please note if this is current or the date that you quit.

Cigarettes (packs) _____ Coffee/Tea (cups) _____ Alcohol (drinks per week) _____

MEDICAL: If you have evern been hospitalized for a serious medical illness or operation, please write the most recent ones below. (Do not include normal pregnancies.)

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Patient Intake Form

MEDICAL: If you have evern been hospitalized for a serious medical illness or operation, please write the most recent ones below. (Do not include normal pregnancies.)

YEAR	OPERATION / ILLNESS

MEDICINES:

What prescription drugs are you currently taking: For what condition?

What over-the-counter medications, herbs, or supplements are you currently taking: For what condition?

Please put a "C" if the condition is current or a "P" if you had it in the past.

General
_____ Insomnia
_____ Dreams/Nightmares
_____ Fatigue
_____ Poor Memory
_____ Strongly Like Cold Drinks
_____ Strongly Like Hot Drinks
_____ Recent Weight Loss/Gain
_____ Chills
_____ Fever

Eyes
_____ Glasses/Contact Lenses
_____ Blurred Vision
_____ Poor Night Vision
_____ Spots or Floaters
_____ Eye Inflammation
_____ Double Vision
_____ Glaucoma
_____ Cataracts

Skin
_____ Hives
_____ Rashes
_____ Eczema / Psoriasis
_____ Night Sweating
_____ Excess Sweating
_____ Dry Skin
_____ Easily Bruised
_____ Changes in Moles, Lumps
_____ Itching

Head & Neck
_____ Headaches
_____ Migraines
_____ Stiff Neck
_____ Dizziness
_____ Fainting
_____ Swollen Glands

Ears
_____ Ringing
_____ Hearing Loss
_____ Hearing Aids
_____ Infections
_____ Earache
_____ Vertigo

Nose, Throat & Mouth
_____ Sinus Infection
_____ Hay Fever/Allergies
_____ Frequent Sore Throat
_____ Difficulty Swallowing
_____ Mouth & Tongue Ulcers
_____ Frequent Colds
_____ Nosebleed
_____ Dry Nose
_____ Nasal Congestion
_____ Loss of Voice
_____ Thirst
_____ Excessive Phlegm
_____ TMJ
_____ Facial Pain
_____ Gum Problems
_____ Dry Mouth

Respiratory
_____ Difficulty Breathing
_____ Difficulty Breathing w/Reclining
_____ Wheezing
_____ Asthma
_____ Chronic Cough
_____ Wet Cough
_____ Dry Cough
_____ Coughing Up Phlegm
_____ Coughing Up Blood
_____ Shortness of Breath
_____ Tight Chest
_____ Pneumonia

Male Genital
_____ Impotence
_____ Premature Ejaculation
_____ Nocturnal Emission
_____ Pain/Itching of Genitalia
_____ Lumps in Testicles

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Patient Intake Form

Cardiovascular

_____ High Blood Pressure
_____ Low Blood Pressure
_____ Chest Pain or Tightness
_____ Palpitation
_____ Rapid Heart Beat
_____ Irregular Heart Beat
_____ Poor Circulation
_____ Swollen Ankles
_____ Phlebitis
_____ Anemia
_____ History of Heart Attack

Neurological

_____ Seizures
_____ Tremors
_____ Numbness or Tingling
_____ Pain (describe)
_____
_____
_____ Paralysis
_____ Poor Coordination
_____ Other (describe)
_____
_____

Gynecology (Women Only)

_____ Currently Pregnant
_____ # of Pregnancies
_____ Miscarriages
_____ Abortions
_____ Menopause
_____ Hormone Replacement Therapy
_____ Irregular Periods
_____ Menstrual Cramps
_____ Excessive Blood Flow
_____ Menstrual Blood Clots
_____ Breast Tenderness
_____ Abnormal Pap Smear
_____ Vaginal Infections
_____ Vaginal Pain / Itching
_____ Uterine Fibroids
_____ Endometriosis
_____ Breast Lumps, Cysts

Gastrointestinal

_____ Nausea
_____ Indigestion
_____ Stomach Pain
_____ Diarrhea
_____ Constipation
_____ Poor Appetite
_____ Excessive Hunger
_____ Vomiting
_____ Gas
_____ Hiccups
_____ Acid Regurgitation
_____ Bloating
_____ Bad Breath
_____ Laxative Use
_____ Bloody Stool

Mental / Emotional

_____ Depression
_____ Mood Swings
_____ Irritability
_____ Difficulty Relaxing
_____ Loneliness
_____ Sensitive
_____ Shy
_____ Cry Often
_____ Worry a Lot
_____ Compulsive Behaviors
_____ Difficulty Focusing
_____ Hopeless Outlook
_____ Suicidal Thoughts
_____ Lose Temper
_____ Frustration

Infection Screening:

(Check Self and/or Partner)

_____ HIV Risk ❑ Self ❑ Partner
_____ TB ❑ Self ❑ Partner
_____ Hepatitis Risk ❑ Self ❑ Partner
_____ History of Sexually Transmitted Diseases ❑ Self ❑ Partner
_____ Gonorrhea ❑ Self ❑ Partner
_____ Chlamydia ❑ Self ❑ Partner
_____ Syphillis ❑ Self ❑ Partner
_____ Genital Warts ❑ Self ❑ Partner
_____ Herpes ❑ Oral ❑ Genital ❑ Self ❑ Partner

Musculoskeletal

_____ Joint Pain / Disorder
_____ Sore Muscles
_____ Weak Muscles
_____ Difficulty Walking
_____ Neck / Shoulder Pain
_____ Upper Back Pain
_____ Lower Back Pain
_____ Rib Pain
_____ Limited Range of Motion
_____ Other (describe)
_____
_____

Urinary

_____ Pain on Urination
_____ Frequent Urination
_____ Urgent Urination
_____ Blood in Urine
_____ Unable to Hold Urine
_____ Incomplete Urination
_____ Bedwetting
_____ Wake to Urinate
_____ Increased Libido
_____ Decreased Libido
_____ Kidney Stones

Other Information

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Referred by: _____

Signature: _____ Date: _____

Shannon Considine, L.Ac., M.Ac.

Licensed Acupuncturist
200 East Joppa Road, Suite 402
Towson, Maryland 21286
410-598-9836

Office Policies

Release of Information: Your insurance company may require medical reports to document our treatment and progress. Your initials below authorize the release of medical information necessary to process your claim.

Initials: _____ Date: _____

Sign: _____

Print Name: _____