JEAN DRUMMOND, L.AC.

NEW PATIENT CONFIDENTIAL INFORMATION

Name: _____ Date: _____

Mailing/Street Address_____ City: _____

State: _____ Zip: _____ Phone: _____ E-mail Address: _____

Sex: M___ F ___ Marital Status: _____ Date of Birth:_____ Age:_____

Occupation: _____ Employers Name: _____

In case of emergency notify: _____ Relationship: _____

Phone: _____ Address: _____

Is this your first time trying acupuncture? Yes ___ No ___

How did you find this office or who referred you? _____

HEALTH HISTORY:

What is your main complaint today? _____

What are your biggest health challenges? _____

On a scale of 1-10 (10 being worst), how would you rate your current Stress level? _____ Past levels? _____

Check the following conditions you currently have or have experienced:

□ Chronic pain	□ Allergies/Hay fever	□ Stress & tension
□ Muscle stiffness	□ Lung issues	□ Anxiety
□ Arthritis	□ Skin issues	□ Depression
□ Osteoporosis	□ Diabetes	□ Irritability
□ Inflammation	□ Thyroid disorder	□ Crying
□ Headaches	□ Autoimmune Disease	□ Insomnia
□ Chronic Migraines	□ Digestive problems	□ Crying
□ Dizziness	□ High blood pressure	□ Insomnia
□ Head injury	□ Cancer or tumors	□ Mood swings
□ Stroke	□ Heart issues	□ Other _____

Current Medications/Supplements: Please list: _____

_____

Allergies to medications/foods? Please list: _____

Any surgeries, hospitalizations, serious or chronic illnesses, or accidents? Please list: _____

_____

I certify that the above information is true to the best of my knowledge and belief.

Signature: _____ Printed Name: _____ Date: _____

LATE CANCELLATION OR NO-SHOW POLICY

Your appointment time is reserved just for you; a late cancellation or no show leaves a hole in the schedule that could have been filled by another patient. Therefore, a 24-hour notice is required for an appointment to be rescheduled. In instances of a cancellation without 24-hour notice or no-show, we reserve the right to charge a $50 fee. If a package has been purchased, one visit will be deducted for each no-show or late cancellation. If there's an emergency, we understand and can make an exception up to two times.

FINANCIAL RESPONSIBILITY POLICY

The fees for office visits are payable at the time of visit. I agree to cover any expenses associated with my acupuncture treatments at the time of treatment. All prepaid packages must be used in a timely manner and will expire in one year from the date of purchase. We do not bill insurance. However, we can provide you a Superbill to submit to your insurance company upon request.

NOTICE of PRIVACY PRACTICES for PROTECTED HEALTH INFORMATION

We want to assure you that your medical and health information is secure with us. Your doctor acts in strict accordance with HIPPA regulations and ensures that your information remains private. You may request a copy of HIPPA guidelines upon request.

CONSENT FOR TREATMENT

I, the undersigned, hereby authorize Jean Drummond, L.Ac., acupuncturist licensed in the State of California, to perform Chinese Medicine procedures. The scope of practice under acupuncture licensure in California may include insertion of sterile needles, electro-stimulation, heat, cupping, dermal friction, acupressure, herbal therapies, nutritional counseling, breathing techniques and exercise; all of these according to Oriental medical principles.

I understand that Jean Drummond, L.Ac. uses only sterile disposable needles and maintains a clean and safe environment. Herbs and nutritional supplements which may be recommended are traditionally considered safe in the practice of Chinese Medicine. I wish to rely on her judgment during the course of the treatment, which she feels at the time, is in my best interest.

I have been informed that acupuncture is a safe method of treatment, but occasionally, while not common, may include the following: minor pain or soreness in the treatment areas that may last up to a few days, temporary bruising or swelling, sensations of heat/cold/ tingling or numbness, skin irritation or slight bleeding at needle site, generalized fatigue, or temporary aggravation of symptoms. I also understand that there are very rare side effects to acupuncture that may include the following: infection at needle site, needle sickness (dizziness, nausea, fainting), broken needles, or pneumothorax.

I agree to contact Jean Drummond, L.Ac. immediately if I experience any problem which I associate with the treatments listed above and will seek immediate help from a physician/hospital if I experience a medical emergency. 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. By signing below, I agree to the above-named procedures.

Signature: _____ Printed Name: _____ Date: _____