Acupoint Health Connection, Inc.
Medical History and Consent to Treatment Form

WELCOME! We would like to make your treatment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let us know.

ALL INFORMATION WILL REMAIN CONFIDENTIAL

Printed Name: _____ Date of Birth:_____

Address: _____ City: _____ State: ___ Zip Code: _____

Phone: _____ Email Address: _____

Have you ever had acupuncture or massage therapy before? _____Yes _____ No

Are you currently taking any medications? _____ Yes _____ No

If yes, please list name and reason for medications_____

_____

_____

Are you currently seeing a healthcare professional? Yes_____ No_____

If yes, please list names and reason/treatment_____

_____

_____

Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

___arthritis
___diabetes
___blood clots
___broken/dislocated bones
___bruise easily
___cancer
___chronic pain
___constipation/diarrhea
___auto-immune condition*
___hepatitis (A, B, C, other)
___skin conditions
___stroke
___surgery
___TMJ disorder
___depression, panic disorder, other psych condition
___diverticulitis
___headaches
___heart conditions
___back problems
___high blood pressure
___insomnia
___muscle strain/sprain
___pregnancy
___scoliosis
___seizures
___whiplash
___chemical dependency (alcohol, drugs)

(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

If any of the above needs to be detailed or if there is anything else to share, please do so:_____

_____

Do you have any of the following today:

_____ skin rash _____ cold/flu _____ open cuts _____ severe pain

_____ anything contagious _____ injuries/bruises

Do you have any allergies to:

_____ medications _____ foods (nuts, etc.)

_____ environmental allergens (dust, pollen,

_____ fragrances) reactions to skin care products

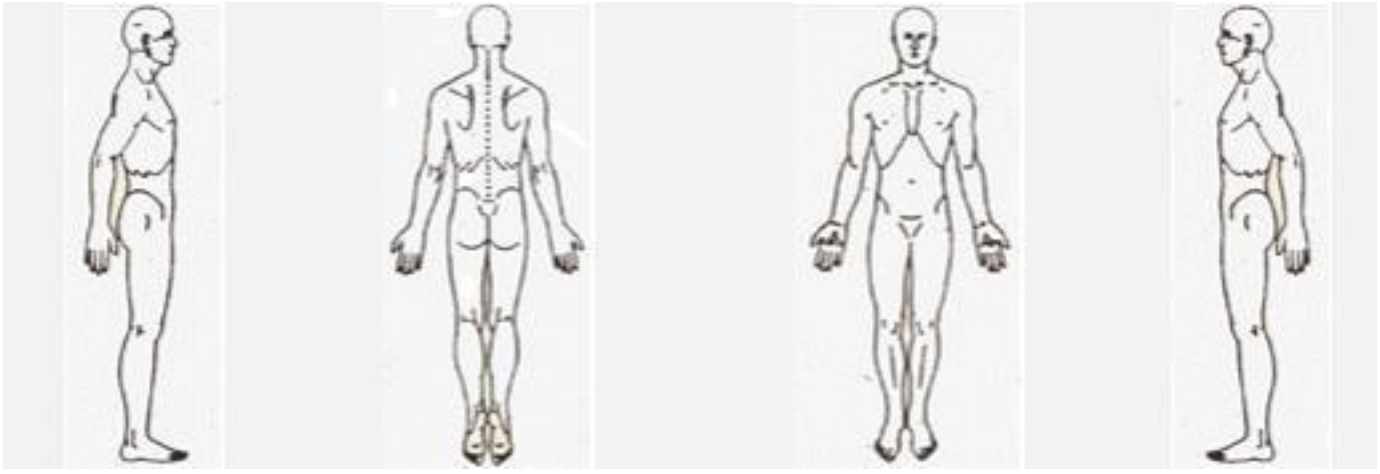
If any of the above are checked, please give details: _____

_____

Are you wearing: _____contact lenses _____ hearing aid _____ hairpiece

FEMALES: When was the date of your last period: _____

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



What are your goals/expectations for this therapy session?_____

_____

_____