



## Patient Info & Consent

Full Legal Name: \_\_\_\_\_ Date: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  M  F Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**\* Are you pregnant or have any reason to believe you may be pregnant?** Yes No

Do you have any infectious/contagious disease? Yes No

If yes, please explain: \_\_\_\_\_

Are you currently suffering from any chronic illness? Yes No

If yes, please explain: \_\_\_\_\_

Are you currently taking any blood-thinning medications such as Coumadin or Warfarin? Yes No

**About Acupuncture:** I understand that acupuncture means the stimulation of certain points on the surface of the body by the insertion of needles through the skin to modify or prevent pain perception and/or to normalize physiological functions in an attempt to treat disease or dysfunctions of the body. I have been made aware that certain adverse side effects may result which could include, but are not limited to: local bruising, minor bleeding, fainting, temporary pain or discomfort, and the possible temporary aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

This clinic is in full compliance with all rules and regulations promulgated by the Colorado Dept. of Health, including the sanitation of acupuncture offices. For the safety of all patients, only pre-sterilized, disposable needles are used.

**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 for treatment by Diana Hermann, Licensed Acupuncturist.**

*Patient Signature* \_\_\_\_\_ *Date* \_\_\_\_\_