Traver Garrity Acupuncture

Date: _____

Name: _____ Gender: _____
Age: _____ Date of Birth: _____ Place of Birth: _____

Address: _____
_____

Primary Phone: _____ Secondary Phone: _____
Email: _____

Emergency Contact: _____ Relationship to Patient: _____
Emergency Contact Phone Number: _____

Experience with Acupuncture
Have you received acupuncture treatment before? YES NO
If yes for what condition and what was the out come? _____
_____

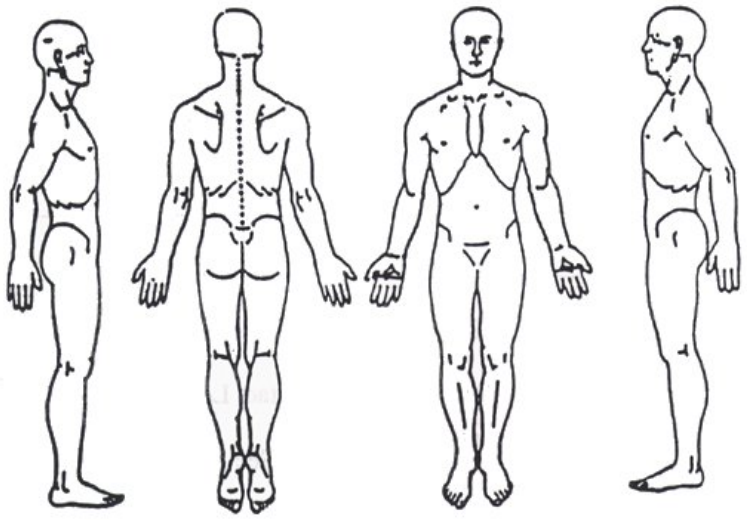
How did you hear about our office?
_____

Description of Major Complaints:

Primary Complaint: _____
How long have you had it? _____
What was the onset? _____
What makes it worse? _____
What makes it better? _____
Have you seen a physician? If so when and what was the diagnosis? _____
_____
Other Care: What other therapies are you doing/have you done to manage your Primary Complaint?
_____
_____

Secondary Complaint: _____
How long have you had it? _____
What was the onset? _____
What makes it worse? _____
What makes it better? _____
Have you seen a physician? If so when and what was the diagnosis? _____
_____
Other Care: What other therapies are you doing/have you done to manage your Secondary Complaint?
_____
_____

Body Chart: Please mark on areas where you feel your symptoms associated with your complaints.



Patient Medical History

Illnesses: List any surgery, accident and/or major illnesses and indicate duration of illness and age.

_____
_____
_____
_____

Please list all medications, supplements and herbs you are currently taking and for what indication.

_____
_____
_____
_____

Family Medical History:

Please note all major illnesses in your close family, e.g. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, blood disorders, high cholesterol, ect…

Mother: _____
Father: _____
Siblings: _____
Maternal Grandparents: _____
Paternal Grandparents: _____

Lifestyle Information:

What type of exercise do you do? _____
How often do you exercise? _____
How many hours do you sleep per night and do you feel rested upon waking? _____

Emotions/Mind:

What is your stress level 0 out of 10 with 10 being the highest? 1 2 3 4 5 6 7 8 9 10
When you are stressed where do you feel it? _____
How do you relax? _____

Women Only:
Menstruation Chart: Please mark symptoms per their occurrence.

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Have you been pregnant or trying to become pregnant? YES NO
Have you ever been pregnant? YES NO
If yes how many Pregnancies: _____
Births _____
Miscarriages _____
Abortions _____

Men Only:
_____ Fertility Concerns
_____ Prostate Problems
_____ Sexual Dysfunction
_____ Unusual Discharge
Other _____

Any other symptoms: _____
_____
_____

I verify that all information provided is accurate to the best of my knowledge. If I have any changes in health or symptoms I will notify the practitioner.

_____
Signature Date

Patient Policies

Acupuncture Patient Agreements

1. **Office Etiquette**- We kindly ask that you keep your voice low while at the center to avoid disturbing other patients. As a courtesy to our patients in treatment, we ask you to avoid talking on cell phones while in the office.

2. **Clothing** - The acupuncture points for your condition will determine the areas of your body that need to be exposed. Please wear clothing that is loose fitting (i.e. pants that can be moved above the knee) or bring shorts. Acupuncture is preformed in a clinical environment and drapes will be provided if necessary.

3. **Hygiene** - As a clinic that sees many people during the day we wish to keep our office as hygienic as possible. We kindly ask that you maintain a level of personal hygiene that will not disrupt the cleanliness of our office or disrupt procedures used by the acupuncturist to keep a clean field and reduce infection during treatment.

4. **Compliancy** – The Acupuncturist may make suggestions within his/her judgment and scope of practice for treatment frequency, dietary changes, or supplements. By not taking these suggestions into account your treatment outcome may not be to its optimal potential.

5. **Cancellation** - If you fail to give the center 24 hours notice of change of appointment or cancellation, the scheduled services fees may be charged for that appointment.

6. **Financial Responsibility**- We expect you to honor the financial agreements you make with the center immediately after or prior to treatment.

7. **Comments or Concerns**- We are here to serve you. Please speak to the acupuncturist or office manager about any comments or concerns you may have. We see your comments as helping us to help you and others.

TRAVER GARRITY ACUPUNCTURE
INFORMED CONSENT

I consent to acupuncture treatments and related procedures, associated with Oriental Medicine by Traver Garrity L.Ac. I have discussed the nature and purpose of my treatment with her and I understand the methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, gua sha, and electrical stimulation. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including, bruising, numbness or tingling near the needle site, which may last a few days. An unusual risk of acupuncture includes, spontaneous miscarriage, nerve damage and organ puncture. Infection is another possible risk, however since this office uses only sterilized, disposable, single use needles while maintaining a clean and safe environment, this is unlikely. Burns and scaring are potential risks of using moxibustion. I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgments during the course of treatment, and decide what she thinks is in my best interest, based upon the facts that are known at the time. I understand the practitioner and administrative staff may review my medical records and reports, but all my records will be kept confidential and will not be released without my written consent. I will notify the acupuncturist who is caring for me if I become pregnant. By voluntarily signing below, I show that I have read or have had read to me, this consent to treatment for both the present condition and for any further conditions for which I seek treatment(s).

ADVISORY TO CONSULT A PHSICIAN

While Oriental Medicine has a great deal to offer as a health care system, it cannot replace the resources available through medical physicians. It is recommended that you consult a physician regarding any conditions for which you are seeking acupuncture treatments.

NOTICE OF PRIVACY PRACTICES FOR HIPPA REGULATIONS

General office practices regarding the protection of your medical information

All information regarding patients, their treatments, diagnosis and appointments is kept strictly confidential within the confines of the practitioners and office assistants and will not be shared unless by signed document from you allowing it.

For treatment purposes only, will information be shared with other practitioners within this practice.

Discussions of treatment is confined to the consultation room or the treatment room and not in the presence of other patients.

We routinely communicate with patients over the phone to schedule and confirm appointments. While the name Traver Garrity Acupuncture is given in messages, no reference to medical services is made. Occasionally we will call and give instructions that herbs or supplements ordered have arrived at our office.

If you prefer not to be contacted, or wish us to use a specific number, please provide that information.

By Signing below I agree to the above office procedures, and consent to the treatment of acupuncture.

_____

Signature of Patient or Patient Representative Date

COVID-19 INFORMED CONSENT TO TREAT
Traver Garrity Acupuncture

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided)

	INITIAL
I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted.	_____
I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time.	_____
I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office.	_____
I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below: *Fever *Shortness of Breath *Dry Cough *Runny Nose *Sore Throat *Loss of Taste or Smell	_____
I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT inthe past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train.	_____
I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care.	_____
I have been offered a copy of this consent form.	_____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS

_____

Signature of Patient or Patient Representative Date

_____

Printed Name