DR QIN ACUPUNCTURE CLINIC

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full name	Sex ☐F ☐M	Date of visit	
DOB Age	Occupation		
E-mail	Phone Number:		
Address: Street	City	State	Zip
Marital status ☐S ☐M ☐D ☐W # of children:			
Have you ever been treated by acupuncture before? ☐Y ☐N	How did you know this clinic?		
Insurance Company:	Plan Name:	Insurance Phone#:	
Insurance ID #:	Group name/ Group number:		
Primary Insured Name:	Primary Insured DOB:		
Deductible:	Copay:		
	# Visits/ Calendar Year:		

Chief Complaint(s):

You would like us to help you with ____

When did this problem begin? ____

Have you been given diagnosis for this problem? If so, what?

____

What kinds of treatment have you tried? ____

Medicines taken

____

History of diseases

____

_____________________________ _______________

Patient Signature **Date**

Request and consent

I hereby request Shuangzhu Qin L.Ac. to treat me. I also authorize her to perform on me the treatment known as Acupuncture as her judgment may indicate and authorize her to use whatever therapeutic methods she may see fit. Whether or not such methods are commonly and generally accepted and practiced in this community.

Shuangzhu Qin has frankly and fully explained to me the nature and purpose of the treatment, the risks involved, including but not limited to mild bruise from needling, possible burns from moxibustion. In giving my consent to the treatment, I have in mind her frank and full explanation. If any unforeseen condition arises in the course of treatment and in the judgment of the Acupuncturist it is advisable to use procedures in addition to or different from those now contemplated, I also request and authorize her to do whatever she deems advisable.

In the event that my condition is such that treatment is beyond the normal capabilities of the acupuncturist. I understand that I may be referred to other competent practitioners including, but not necessarily limited to, medical physicians or other acupuncturist.

I also agree to give 24 hours notice if I am going to be unable to make my scheduled appointment. I fully understand I will be charged the regular fee if I miss an appointment without giving 24 hours notice.

________________________ _________________________________

Date Signature of Patient