acupuncture
SHREVEPORT

745 Olive Street, Suite 212 | Shreveport, LA 71104
318.459.9125 | www.shreveportacupuncture.com

Ofc. use, Patient No.: _____

Full Name _____ Date of birth _____ Age _____

Street Address _____ Phone (_____) _____

City _____ State _____ Zip _____

Email Address _____ Cell Phone (_____) _____

Occupation _____

Emergency Contact _____ Phone (_____) _____

Have you had acupuncture before? Yes_____ No_____

FOR OFFICE USE

Have you experienced any of the following in the last two months?

☐ Headache	☐ Low appetite
☐ Fever	☐ Gas/bloating
☐ Chills	☐ Constipation
☐ Cough	☐ Diarrhea
☐ Heart palpitations	☐ Acid reflux
☐ Night sweats	☐ Depression
☐ Poor memory	☐ Anxiety
☐ Poor concentration	☐ Restlessness
☐ Bladder dysfunction	☐ Cold hands & feet
☐ Erectile dysfunction	☐ Vivid dreams

Reason for seeking treatment _____

_____

Is your blood pressure usually high _____ normal _____ low _____

List all medications and supplements _____

_____

_____

List known allergies _____

_____

List surgeries _____

_____

List chronic or recurring conditions (examples: diabetes, asthma, migraines)_____

_____

Meredith L. Stewart, ACA, MAOM
Acupuncture and Herbal Medicine
745 Olive Street, Suite 212
Shreveport, LA 71104
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Cancellation Policy

Please Honor Your Appointments

If you are unable to make your appointment, kindly let us know 24 hours in advance. We have a waiting list and others would like to have your appointment time if you are unable to make it. Missed appointments, or those cancelled with less than 24 hours notice, will be billed at the rate of $40. Please note: if you are more than 15 minutes late, your appointment will be considered a cancellation. We understand that illnesses, accidents and events come up that can prevent you from keeping your appointment and will extend a one-time exception for a missed appointment without notification.

I have read and understand this Cancellation Policy.

Name (Please Print)_____

Signature_____ Date_____

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Acupuncture Informed Consent To Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand the results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

NAME (PLEASE PRINT) _____

SIGNATURE _____ DATE _____

(Or Patient Representative. Please indicate relationship if signing for patient.)

ACUPUNCTURIST: Meredith L. Stewart, ACA, MAOM