



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

Ofc. use, Patient No.: _____

Full Name _____

Date of birth _____

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?

- | | |
|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Low appetite |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Gas/bloating |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Acid reflux |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Restlessness |
| <input type="checkbox"/> Bladder dysfunction | <input type="checkbox"/> Cold hands & feet |
| <input type="checkbox"/> Erectile dysfunction | <input type="checkbox"/> 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) _____



Authorization

Allowing Supervising Physician to Review your Medical Records

Under Louisiana law, a non-physician acupuncturist must have a medical doctor periodically review a random sampling of his or her patients' files. The supervising physician for Meredith L. Stewart is Dr. Barron O'Neal, a surgeon with more than 30 years of experience in medical practice. Your signature below authorizes the release of your private healthcare information from Acupuncture Shreveport to Dr. O'Neal in the event that your file is chosen among the random sampling.

Name (Please Print) _____

Signature _____ Date _____

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 \$36.00. 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 the "Cancellation Policy."

Name (Please Print) _____

Signature _____ Date _____