doren@DorenDay.com **Doren Day, L.Ac.** 215.360.2515

Client Intake Form

Name: _____

Address: _____

City: _____ State: _____
ZIP: _____

Primary Phone #: _____

Can I text this #? Yes/No
Can I leave a voice message? Yes/No
Emergency Contact Name:

_____

Phone #: _____

Relationship: _____

How did you hear about this practice?

_____

Birth Date: _____ Age: _____
Gender:_____
Occupation: _____

Are you a student?_____

Primary Physician: _____
Phone #: _____

Are you in a committed relationship? Yes/No
Spouse or Partner's Name: _____

Do you have children? Yes/No
If yes, their ages? _____

What is the most important change you'd like to see through your work with me? What symptoms or issues would you like help with?

_____
_____
_____
_____

When did each concern begin?

_____

Do you know (or have a sense of) what may have caused it?

_____

To what extent does it interfere with your daily life? (work, exercise, sleep, relationships, etc)

_____
_____

Have you been given a diagnosis? Yes/no If yes, what and from whom?

_____

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What other treatments have you tried? Did they help? Are you still receiving them?

_____

_____

Is there anything that helps - or worsens - your concern/symptoms?

_____

_____

Medications/Supplements:

Please list all medications you are currently taking, including over-the-counter medications, as well as vitamins, minerals, herbs, and supplements:

_____

_____

_____

_____

Are you currently taking an anticoagulant medication (blood thinner)? Yes/no

Past Medical History:

Do you have any cardiac/heart conditions?

_____

Please list any surgeries or hospitalizations (including the dates) Include any implanted devices, breast enhancement, pacemaker, pins, screws:

_____

_____

_____

_____

_____

Are you pregnant? _____ Are you trying to conceive? _____

Do you currently use birth control? If so what type _____

Age of menopause (if applicable) _____ Any ongoing hormonal symptoms? _____

Doren Day, L.Ac., Dipl. Ac.
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DISCLOSURE STATEMENT
CONSENT FORM
MEDICAL INFORMATION PRIVACY

* This office is compliant with the HIPPA regulations regarding patient privacy. Your records and information will be kept confidential except as mandated by law.
* Only single-use, disposable, factory-sterilized needles are utilized.
* Clients are entitled to receive information about the methods of therapy, techniques used, and the duration of therapy, if known.
* Clients may seek a second opinion and may terminate therapy at any time.
* In a professional relationship, sexual intimacy is never appropriate.

If you have comments, questions, or complaints, contact - in Pennsylvania, the State Board of Medicine, P.O. Box 2649, Harrisburg, PA 17105-2649.

Doren received her acupuncture degree from The Institute of Taoist Education and Acupuncture in Louisville, CO in 2004. This four year program consists of 2000 hours of education including over 500 hours of clinical practice. She was certified as a Diplomate in Acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in March of 2004. She has obtained certification in Clean Needle Technique from the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM). Doren is a Certified Zero Balancing practitioner. Doren is a member of the Association for Professional Acupuncture and is a licensed acupuncturist in Pennsylvania and Colorado. Her license has never been suspended or revoked.

Fee Schedule

Intake Consultation and Diagnosis	$185.
Acupuncture Treatment	$135.
Tune-Up session	$65.
Package of 4 sessions	$480.

I understand that:

- Acupuncture is performed by the insertion of special needles through the skin, or by applying heat via moxibustion or by any combination of the foregoing, at certain points on the body.
- Moxibustion is the use of the herb *Atemisia Vulgaris* on the skin to warm the point before treatment.
- Certain side effects may result from treatment. These could include, but are not limited to, local bruising or bleeding, fainting, weakness, nausea, temporary pain or discomfort and the possible aggravation of symptoms existing prior to acupuncture treatment.
- No guarantee is made concerning the outcome of these acupuncture treatments, and I may stop them at any time.
- Massage and bodywork is not intended to be painful. I will give feedback during the process to keep the pressure at a comfortable level.
- None of the foregoing provisions shall prevent the administration of medical treatment by a licensed physician when such treatment is deemed appropriate.
- Payment shall be made in full at the time of treatment. A $55 fee will be charged for all missed appointments. ***All cancellations and appointment changes must be made 24 hours in advance of the scheduled appointment time***.
- I will inform the acupuncturist if I become pregnant or am in the process of trying to become pregnant.

I have read and understand this disclosure and information privacy statement, and voluntarily consent to be treated by acupuncture.

_____ _____
Patient's or Guardian's Signature Date