PARKING: please park in the driveway curve and leave open access to the garage! Thank you!

Jack Morris AP Dipl Ac (NCCAOM)

Acupuncture Intake Form

TO EXPERIENCE THE BEST TREATMENT POSSIBLE PLEASE:
* Eat lightly an hour or so before your app appt.
* Dress in loose comfortable clothing- Shorts are best!

Personal Information

Patient Name:_____

Age:_____ Birth Date:____/____/____ Gender:_____

Address:_____

City:_____State:_____Zip: _____

Telephone (Day):_____

Telephone (Night):_____

Telephone (Mobile):_____

Email Address:_____

Occupation: _____

Referral Source: _____

Who is your primary health care provider/MD? _____

Emergency Contact: _____Phone:_____

Main Complaint

Please identify your major health concerns

1. _____

   _____

   How long have you had this problem? _____
2. _____

   _____

   How long have you had this problem? _____
3. _____

   _____

- ☐ How long have you had this problem? _____
- ☐ Have you been given a diagnosis for these problems? _____
- ☐ What other treatments have you tried and what were the outcomes? _____

  _____

  _____

Personal Medical History *(Please include your childhood history)*

Illnesses	
Surgeries	
Significant Trauma: (i.e. motor vehicle accidents, fractures, etc.)	
Do have a history of current or past infectious disease? Please describe	
Medicines (please list all medications, herbs, vitamins and over the counter drugs)	
Allergies/Sensitivities (Please list any foods, drugs, medications or environmental factors which you are sensitive or allergic to)	

General (please check all that apply)

- ❑ Poor Appetite
- ❑ Hearing Loss
- ❑ Easy to Bleed or Bruise
- ❑ Strong Thirst
- ❑ Puffiness or Swelling
- ❑ Night Sweats
- ❑ Changes in Appetite
- ❑ Weakness
- ❑ Fevers
- ❑ Sweat Easily
- ❑ Poor Sleep
- ❑ Poor Balance
- ❑ Cravings
- ❑ Other:
- ❑ Sudden Energy Drops
- ❑ Chills
- ❑ Fatigue
- ❑ Tremors
- ❑ Weight Loss
- ❑ Weight Gain

Skin & Hair

- ❑ Rashes
- ❑ Skin Ulcers
- ❑ Hives
- ❑ Itching
- ❑ Eczema
- ❑ Pimples
- ❑ Dandruff
- ❑ Hair Loss
- ❑ Recent Moles

Head, Eyes, Ears, Nose, and Throat

- ❑ Dizziness
- ❑ Cataracts
- ❑ Taste/Smell Problems
- ❑ Eye Strain/Pain
- ❑ Nose Bleeds
- ❑ Migraines
- ❑ Recurrent Sore Throat
- ❑ Toothache
- ❑ Ear Ringing
- ❑ Headaches
- ❑ Night Blindness
- ❑ Facial Pain
- ❑ Ear Aches
- ❑ Lip or Tongue Sores
- ❑ Blurry Vision
- ❑ Sinus Problems
- ❑ Concussions
- ❑ Poor Hearing
- ❑ TMJ Pain
- ❑ Spots in Front of Eyes
- ❑ Floaters

Cardiovascular

- ❑ High Blood Pressure
- ❑ Cold Hands or Feet
- ❑ Swelling of Hands
- ❑ Phlebitis
- ❑ Low Blood Pressure
- ❑ Blood Clots
- ❑ Swelling of Feet
- ❑ Fainting
- ❑ Irregular Heartbeat
- ❑ Palpitations
- ❑ Chest Pain
- ❑ Lightheadedness

Respiratory

- ❑ Cough
- ❑ Phlegm
- ❑ Asthma
- ❑ Bronchitis
- ❑ Coughing Up Blood
- ❑ Painful Breathing
- ❑ Difficulty Breathing
- ❑ Pneumonia
- ❑ Easily Winded

Gastro-Intestinal

- ❑ Nausea
- ❑ Bad Breath
- ❑ Chronic Laxative Use
- ❑ Indigestion
- ❑ Blood in Stools
- ❑ Constipation
- ❑ Ulcers
- ❑ Vomiting
- ❑ Rectal Pain
- ❑ Hemorrhoids
- ❑ Diarrhea
- ❑ Abdominal Pain
- ❑ Intestinal Gas
- ❑ Belching

Urology

- ❑ Painful Urination
- ❑ Decrease in Urine Flow
- ❑ Cloudy Urine
- ❑ Pain in Groin Area
- ❑ Urgency to Urinate
- ❑ Frequent Urination
- ❑ Kidney Stones
- ❑ Sexually Transmitted Disease
- ❑ Unable to Hold Urine
- ❑ Blood in Urine
- ❑ Frequent Night Urination

Neuro-Psychological

- ❑ Seizures
- ❑ Twitches
- ❑ Irritability
- ❑ Poor Memory
- ❑ Tremors
- ❑ Areas of Numbness
- ❑ Lack of Coordination
- ❑ Loss of Balance
- ❑ Anxiety
- ❑ Concussion
- ❑ Depression
- ❑ Stress
- ❑ Mood Swings

Gynecology

- _____ Age of Menses
- _____ Duration of Menses
- _____ Date of Last Menses
- _____ # of Pregnancies
- _____ # of Births
- ❑ Irregular Periods
- ❑ Painful Periods
- ❑ Breast Lumps
- ❑ Spotting
- ❑ Vaginal Discharge
- ❑ Clots
- ❑ PMS
- ❑ Menopausal
- ❑ Yeast Infections
- ❑ Fertility Problems

Musculo-Skeletal

- ❑ Arthritis
- ❑ Muscle Spasms
- ❑ Pain with Weather Changes
- ❑ Muscle Weakness
- ❑ Scoliosis
- ❑ Pain with Activity
- ❑ Muscle Cramping
- ❑ Weak Joints
- ❑ Pain After Waking

Basic diet

Please give a description of your daily diet including main meals, snacks and drinks

Typical Diet: Meals per day # of Snacks Caffeinated Drinks Alcohol per week

_____

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

What foods are your weakness?_____

Water intake per day _____Prefer warm or cold drinks _____

Excessively thirsty?_____

Special Diet:_____

INFORMED CONSENT FOR MICROCURRENT FACIAL TREATMENT

PATIENT NAME:_____

ACUPUNCTURIST:_____ CLINIC:_____

CONSENT: I hereby request and consent to Microcurrent facial treatment by the acupuncturist named above 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 above, including those working at the clinic or office listed above or any other office or clinic whether signatories to this form or not. I understand that Microcurrent treatment is not a surgical procedure and is in no way intended as a substitute for cosmetic surgery.

TYPE OF CARE: I have had an opportunity to discuss with the acupuncturist named above the nature and purpose of the Microcurrent treatment to which I am consenting. I understand that a Microcurrent treatment involves the placing of electronic probes to the face, neck and body, and that according to the theory of Traditional Chinese Medicine (TCM) the placing of these probes is designed to facilitate the flow of Qi (energy) along meridians or pathways throughout the entire body. A description of the specific type of Microcurrent care currently contemplated follows:

_____

_____

I understand that my treatment may be modified to address: 1) Changes in my condition, 2) Changes in my desired results, or 3) Changes in the professional standards of acupuncture care. I understand, and agree to adjustments in my treatment as needed to optimally address my well being, my objectives, and to take advantage of the full range of care options for me.

POTENTIAL BENEFITS: I understand that the purpose of Microcurrent treatment is to create a younger and more vibrant appearance by properly balancing the flow of Qi. This may include enhanced skin tone, improved luster of complexion, decreased puffiness around the eyes, elimination or reduction of fine wrinkles, improved muscle tone, a firming of sagging skin, and a lessening of the visible signs of aging. However, I understand that as with all TCM care, Microcurrent treatment involves a gradual, healthful process that is customized for each individual, and that results may vary.

NO GUARANTEE: I understand that results are not guaranteed. My questions regarding longevity of results and potential changes in my facial appearance have been answered. I understand that although good results are hoped for, there is no guarantee or warranty, either expressed or implied, of the results that may be obtained.

RISKS OF MICROCURRENT – I understand that every procedure involves a certain amount of risk, including Microcurrent treatments. Some of the more common complications are listed immediately below. I understand and am informed that even though the majority of patients do not experience these complications, problems may arise for me:

- **BLEEDING AND BRUISING** – As with acupuncture in general, some minor bleeding may occur. This is normal and usually will not leave a bruise. Occasionally, a bruise or a hematoma may appear. With bruising, it is important that you wear sunscreen when going outside. Topical and internal remedies will be discussed to address bruising. If swelling persists, I understand, I should call my provider immediately.
- **INFECTION** – Infection at the probe site is very rare after treatment because the probe does not break the skin. If you suspect infection at the probe site (i.e. redness, swelling or warm to the touch), please call me. Additional treatment or referral to your M.D. may be necessary.
- **DAMAGE TO DEEPER STRUCTURES** – In certain systems, deeper structures such as blood vessels, nerves and muscles are rarely damaged during the course of a Microcurrent treatment procedure. If this does occur, the injury may be temporary or permanent.
- **ASYMMETRY** – All facial structures are naturally asymmetrical. Results may vary from side to side due to the natural asymmetry, previous injuries on one side of the body, or severity of symptoms from one side or the other.

- **NERVE INJURY** – Injury to the motor or sensory nerve very rarely results from Microcurrent treatments. Nerve injuries may cause temporary or permanent loss of facial movements and feeling. Such injuries may improve over time. Injury to the sensory nerves of the face, neck and ear regions may cause temporary or, more rarely, permanent numbness. Painful nerve scarring is extremely rare.
- **UNSATISFACTORY RESULT** – There is the possibility of a poor result from a Microcurrent procedure. You may be disappointed with the results.
- **ALLERGIC REACTIONS** – In rare cases, local allergies to topical preparations have been reported. Allergic reactions may require additional treatment or discontinuation of treatment.
- **DELAYED HEALING** – Delayed healing is a rare complication. Smoking and certain health conditions such as diabetes and chronic fatigue syndrome, to name a few, may delay the healing response of any of the aforementioned risks.
- **UNSATISFACTORY RESULTS** – I understand that I am not having a surgical procedure. The alternatives, risks, and comparisons of surgical procedures versus Microcurrent have been discussed with me and outlined in this document. Should I have any further questions, I will discuss them with my provider before treatment begins.
- **LONG TERM EFFECTS** – Following Microcurrent treatments, changes in facial appearance may occur as the result of the normal process of aging, weight loss or gain, sun exposure, stress, illness, or other circumstances not related to Microcurrent. It has been explained that following lifestyle and dietary instructions may enhance the longevity of the Microcurrent treatment while non-compliance will adversely affect the longevity of the Microcurrent treatment. Additional, future treatments may be necessary to maintain the results.
- **UNFORESEEABLE IMPACTS** – There are many variable conditions, in addition to the risks and potential complications enumerated that may influence the long term result from Microcurrent. While the complications cited are the ones particularly associated with Microcurrent, this is not an exact science, and other less common complications may arise. Should these or other complications occur, other treatments might be necessary.

ALTERNATIVE TREATMENT – I understand that other alternatives exist for cosmetic care including but not limited to surgery, such as a surgical facelift, chemical face peels, or liposuction. I realize that there are also risks and potential complications associated with these alternative forms of treatment.

HEALTH INSURANCE/FINANCIAL RESPONSIBILITY – I understand that most health insurance does not cover the cost of the Microcurrent treatments or complications resulting from such treatments. Please contact your insurance if you have any questions about coverage. Depending on whether any or all of the cost of Microcurrent is covered by an insurance plan, I will be responsible for charges not so covered.

UNFORESEEN CONDITIONS – I understand that there are several styles or methods of facial, cosmetic, or rejuvenation acupuncture and have been informed that during the course of Microcurrent treatments, unforeseen conditions may necessitate different procedures than those listed above.

AGREEMENT AND CONTINUOUS EFFECT: I have read, or have had read to me, the above consent. It has been explained to me in a way that I understand: a) The risks involved with Microcurrent, b) That I have alternatives available to me for cosmetic improvements, and c) What protocols will be used in connection with treatment. I have also had an opportunity to ask questions regarding Microcurrent treatment, and am satisfied that all my questions have been answered. I acknowledge that no guarantee has been given to me by anyone as to the results that may be obtained. I authorize the release of medical information, when required. Finally, by signing below I acknowledge that I have been fully informed about, and agree to, Microcurrent treatments. 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.

PATIENT SIGNATURE X

(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE X

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
(You may refuse to sign this acknowledgement)

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____
Patient's Signature Parents Signature

_____ _____
Print Name Print Name

_____
Date

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

* Individual refused to sign
* Communications barriers prohibited obtaining the acknowledgement
* An emergency situation prevented us from obtaining acknowledgement
* Other (Please specify)_____

_____
_____
_____

Jack S. Morris A.P. Dipl Ac (NCCAOM)
6634 Willow Park Dr. Suite 200
Naples, Fl. 34109
239-293-4005

Cupping Therapy
Client Release Form

- I understand that all treatments at this facility are therapeutic in nature. I agree to communicate to the therapist any physical discomfort or draping issues during the session.
- Information has been provided to me about Cupping Therapy. If I choose to experience these therapies during treatments, I understand the potential effects and after-care recommendations.
- It has been explained to me that there are contraindications for Cupping Therapy. I have fully disclosed all health factors to my therapist, including those not mentioned on my Health History Intake Form, to avoid any complications.
- It has been explained to me that there is the possibility of discolorations that can occur from the release and clearing of stagnation and toxins from my body.
- I also understand that this reaction is not bruising, but due to cellular debris, pathogenic factors and toxins being drawn to the surface to be clear away by my circulatory systems.
- I further understand that the discolorations will dissipate from a few hours to as long as 2 weeks in some cases and in relation to my after-care activities.
- I understand that Cupping Therapy modalities should not be combined with aggressive exfoliation, 4 hrs after shaving, after a sunburn or when I'm hungry or thirsty.
- I understand that I should avoid exposure to cold, wet, and/or windy weather conditions, hot showers, baths, saunas, hot tubs and aggressive exercise for 24 hours. It has been explained to me that exposure to such extremes can produce undesirable effects and I should avoid such situations.
- I understand that I should avoid caffeine, alcohol, sugary foods and drinks, dairy and processed meats and I should consume an abundance of clean water.

I _____ agree to allow the Cupping Practitioner to perform Cupping. I also agree that I have read, understand and will follow all of the information stated above and will not hold the practitioner responsible.

Date_____ Signature of Client _____

Print Name _____

Date_____ Signature of Practitioner _____

Print Name _____