NEW COMMUNITY CLIENT INTAKE FORM

Name: _____ Date: _____

Pronoun: ☐ He/Him ☐ She/Her ☐ They/Their ☐ Other: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Primary Phone: _____ Date of Birth: _____

Emergency Contact & Phone: _____

Occupation: _____ Have you received acupuncture before? ☐ Yes ☐ No

Who are your current physicians? _____

Are you being treated for a ☐ Work-related Accident? ☐ Auto Accident?

Please list your top three concerns/goals in order of importance to you:	**Mark an X on the scale to indicate severity of condition:**
1.	1 10
2.	1 10
3.	1 10

DID YOU KNOW? Many Maryland residents have insurance coverage for private acupuncture. We make it easy to find out if you're covered. Just provide the following info and give us 2-3 business days.

Insurance Co: _____ Insurance Ph #: _____

Member ID: _____ Group #: _____

Are you the primary policyholder? ☐ Yes ☐ No (if no, please provide primary policyholder's Name and DOB)

Primary Policyholder's Name: _____ *DOB:* _____

For office use only:
☐ MB ☐ SC ☐ UP ☐ P-N ☐ P-R ☐ IN REV 3/20

FLIP OVER FOR NEXT PAGE

How did you hear about us?

- ☐ Friend, Family or Colleague
- ☐ Health Practitioner
- ☐ Picked up Postcard, Coupon or Misc Print Material
- ☐ Walked-by or Live in the Neighborhood
- ☐ Google or Internet search
- ☐ Yelp
- ☐ Facebook/Instagram
- ☐ Other: .....

If a client or health practitioner referred us, we want to thank them!

Client (friend, family, colleague): .....

Health Practitioner or Practice: .....

PATIENT INFORMED CONSENT

Please read and initial:

I agree to receive acupuncture treatment by the licensed acupuncturists of Mend Acupuncture. I have been informed that acupuncture is very safe, but it may have side effects, including bruising, numbness, or tingling near the needling sites that may last a few days, and in very rare cases dizziness or fainting. On occasion current symptoms may worsen before they find relief. I also understand that no guarantee can be made concerning the results of the treatment.

Pregnancy: If I am pregnant or become pregnant, I will notify my practitioners ***immediately*** (if applicable). _____

Late/Cancel Policy: I understand that I may be charged the full session fee when an appointment is missed. I understand that I waive my session if I am more than 15 minutes late. _____

Clinical Practices: I understand that the acupuncturists of Mend Acupuncture use only sterile, disposable, single-use needles, practice safe needling techniques, and maintain a clean and safe environment. _____

Coordination of Care: I understand that the Mend practice may reach out to medical providers to introduce our services. No confidential information will be released. I understand that the clinical and medical staff may review my files but all my records will be kept confidential and can only be released under my personal written consent, or when required by law. _____

I have read this form and had an opportunity to ask questions about its content. 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.

....

Print Name Signature

.....

Date

For patients under 18 years of age:

....

Parent/Guardian Name Parent/Guardian Signature

.....

Date
