Welcome to Meridian Acupuncture.

As a practitioner of Traditional Oriental Medicine, I offer an integrated approach to health, including acupuncture, health coaching, herbs and nutrition. My goal is to provide the highest quality medical care by combining traditional wisdom with modern methods. I am committed to helping you achieve health and vitality through a program of healing, prevention, and education. I believe the quality of your health determines the quality of your life.

Enclosed are the intake forms for you to fill out. Please complete and bring them to your appointment. The initial intake and treatment will take approximately 75-90 minutes. I recommend a protein-rich meal within two hours before each treatment and no refined sugar or caffeine due to acupuncture's strong effect on the body.

For your convenience, I accept cash, checks, and credit cards. I am also happy to check if your insurance covers acupuncture.

The information requested below will assist us in treating you safely and effectively. All information provided will be kept confidential unless permission is provided by you or required by law. Your written permission will be required to release any information, such as billing your insurance.

Thank you for choosing Meridian Acupuncture & Wellness Center. I look forward to meeting you.
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Sincerely,

Chantelle DeShazer, L.Ac., Ph.D, M.T.O.M.

2831 Camino Del Rio South, Suite 218 ◆ San Diego, CA 92108
Phone 619-325-0771 ◆ Fax 619-876-5077 ◆ www.meridianacupuncture.net

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Today's Date _____

First Name: _____Last Name: _____

Address: _____

City: _____State: _____Zip Code: _____

Telephone: (H)_____(W) _____(C) _____

E-mail: _____

Occupation: _____ Employer:_____

Date of Birth: _____ Age:_____ Sex: M / F Marital Status:_____

# of children:_____

Height: _____ Weight: _____ Ideal Weight: _____

Emergency Contact:

_____ _____ _____

(Full name) (Relation) (Telephone)

Name of Medical Doctor: _____ Telephone: (____)_____

Have you been treated by an Acupuncturist? Other health practitioners?

Name: _____ Name: _____

When?_____ When? _____

Please list in order of importance your primary health concerns/reason for your visit:

_____

Please indicate any treatments that you have tried previously to address your health issues and how effective you found these treatments.

_____

Please list all supplements or medications you have taken to treat this issue:

_____

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ACUPUNCTURE QUESTIONNAIRE

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Name: _____ Date: _____

Major complaint(s): _____

_____

_____

_____

Other complaints: _____

_____

Date of onset (when you first noticed the problem): _____

Pain is: Minimal___ Slight___ Moderate___ Severe___

How long have you had this condition? _____

Have you had this in the past? Yes___ No___: When? _____

What makes it better?_____

What makes it worse? _____

Is your condition: Getting better____ Getting worse____ Constant____ Comes & Goes____

Medications/Drugs/Herbs you are currently taking: _____

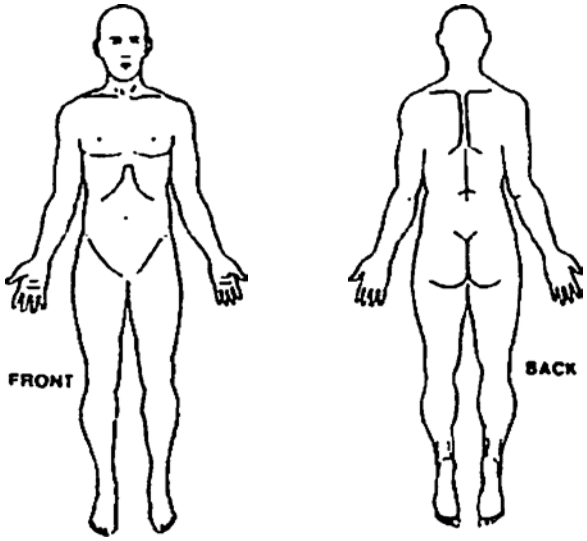
_____

List Surgeries/Operations you've had and dates: _____

_____

Date of last physical examination: _____By whom:_____

MARK YOUR AREAS OF PAIN



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Please check if you've experienced any of the following symptoms in the past 6 months.

☐	lack of appetite	☐	eye problems
☐	excessive appetite	☐	jaundice (yellowish eyes or skin)
☐	loose stool or diarrhea	☐	difficulty digesting oily foods
☐	digestion problems, indigestion	☐	gall stones
☐	vomiting	☐	light colored stool
☐	belching, burping or heartburn	☐	soft or brittle nails
☐	feeling of retention of food in the stomach	☐	easily angered or agitated
☐	obsessive tendencies in work, relationships	☐	difficulty making plans or decisions
☐	insomnia, difficulty sleeping	☐	spasm or twitching of muscles
☐	heart palpitations	☐	low back pain or sciatica
☐	cold hands and feet	☐	knee problems
☐	nightmares	☐	hearing impairment
☐	mentally restless	☐	ear ringing
☐	abdominal pain	☐	kidney stones
☐	chest pain	☐	decreased sex drive
☐	headaches	☐	hair loss
☐	cough	☐	urinary problems
☐	shortness of breath	☐	fatigue
☐	decrease sense of smell	☐	edema
☐	nasal problems	☐	blood in stool
☐	feeling of claustrophobia	☐	asthma
☐	bronchitis	☐	easily bruised
☐	colitis or diverticulitis	☐	tendency to catch colds easily
☐	hemorrhoids	☐	dizziness
☐	recent use of antibiotics	☐	tendency to taint easily
☐	constipation	☐	intolerance to weather changes
☐	skin problems	☐	allergies

Family History: Has any member of your famly had any of the above? If yes, which member and what did they have?

_____

_____

Please list any additional comments:

_____

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Payment
I, the undersigned, understand that payment for all care received is my responsibility.

Initial_____

Cancellation Policy
The time you schedule is reserved just for you. Your treatment schedule is designed for optimal results. Missed appointments will hinder your progress. At times we have a waiting list of people wanting specific times . We request that if you cannot make an appointment, to please call and let us know, so we may fill that time slot. **A 24 hour cancellation notice is necessary to avoid $45 cancellation fee .**

Initial_____

Insurance and Worker's Compensation
I authorize the release of any medical or other information necessary to process my insurance claim. I also request payment of government benefits to Meridian Acupuncture & Wellness, Inc. should my case be accepted. I authorize payment of medical benefits to Meridian Acupuncture & Wellness Center, Inc. for services billed to my insurance carrier. **I understand that if my insurance does not pay, I am accountable for all costs for services rendered.**

Initial_____

Informed Consent
I hereby request and consent to the performance of Acupuncture and other Oriental Medical procedures by the Licensed Acupuncturists at Meridian Acupuncture & Wellness Center, Inc., or associates, or employees. **I understand that infrequently, a small amount of bruising or bleeding may accompany an acupuncture treatment or associated modality .**

Initial_____

Notice of Patient Privacy Health Insurance Portability & Accountability Act (HIPAA)
Meridian Acupuncture & Wellness Center, Inc. is dedicated to preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice how your medical information may be used and disclosed and you can access that information. Required by law: We must have written consent before we disclose your medical information. We may be required by law to disclose your medical information . You are provided the right to inspect and receive a copy of your medical records. If you have any concerns about the Notice or medical information, please contact the office manager. You may also send a written complaint to the US Department of Human and Health Services.

Initial_____

Signature : _____ Date:_____

Printed name:_____

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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 . Bums 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, stomach ache, 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 that 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.

Are you pregnant? Y / N

Meridian Acupuncture & Wellness Center Inc. ACUPUNCTURIST NAME: __Chantelle DeShazer, L.Ac.

Patient Printed Name(or Name if a Minor)_____

Patient Signature: _____

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