Sacred
the way you move

Welcome
to Sacred Community Acupuncture!

Sacred Brooklyn and Oceans & Rivers are excited to welcome you to community acupuncture! Community acupuncture is community *supported* acupuncture, and by supporting this sacred space, you are participating in making the benefits of acupuncture accessible to more people than previously possible. You are also participating in receiving acupuncture in the context of a community of other people who, like yourself, have come to acupuncture because they need help with something. We are, after all, all in this together. Thanks for being here.

In the spirit of community, here are a few of our guidelines to ensure that everyone has a great experience with us:

- Cell phones must be turned off in the community treatment room.
- Plan to spend about 60-75 minutes with us. Follow up treatments may not take as long. While typically a treatment lasts about an hour, we'll leave you as long as you look like you're resting soundly. So please give us a sign if you're done - or be sure to let us know if you need to be out by a certain time.
- Please be on time for your appointment.
- Please do not wear cologne, perfume, or scented lotions. Many people are sensitive to smells.
- Please eat a little something beforehand. Acupuncture is not recommended on an empty stomach.
- Wear loose, comfortable clothing with sleeves that can be rolled up to the elbows and pants that can be rolled up to the knees.
- Please be considerate of others in the group treatment room. Quiet is appreciated. Most people fall asleep when they get acupuncture.

About our sliding scale:
Our community acupuncture treatments are offered for $30, $40, or $50 per treatment.
The reason we offer a sliding scale is to make sure you can come in for acupuncture often enough and long enough to really see changes in your life. We know that everyone's financial situation is different, and it's none of our business what you earn or how you spend it. What we DO care about is that you can commit to this process of healing and transformation. In order to do that successfully, you may need to come in several times per month for a few months. So as you decide what to pay, please think about what you can comfortably commit to.

Note: there is an additional $10 New Patient fee with your first appointment.

Cancellation policy agreement:
If you have an appointment with us and need to reschedule, please do so within 24 hours of your appointment. If not, you will be charged a missed appointment fee of $20.

I have read and agree to the above:

Signature of patient or guardian **Date**

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Health History Questionnaire and Registration

Patient Information

Date_____

Name_____

Address_____

City State Zip_____

Age_____ Birthdate _____

Occupation _____

Company name _____

Primary physician _____

Physician phone number_____

How did you hear about us? Please give person's name, specific ad, etc_____

Contact Information

Home phone _____

Work phone _____

Other/cell phone _____

Email _____

Another person we may contact if needed:

Name _____

Relationship_____

Home phone _____

Work phone_____

Health History

What are your primary concerns for coming in for treatment?

1- _____

2 - _____

3 - _____

How is your sleep? _____

_____

How is your digestion? _____

_____

List medications or food supplements you are taking.

_____

_____

List serious illnesses, accidents or surgeries.

_____

_____

Check illnesses that have occurred in blood relatives.

c Diabetes c High blood pressure c Stroke
c Cancer c Heart disease c Kidney disease

Check symptoms you have or have had in the last year:

- □ Depression
- □ Difficulty in focusing
- □ Dizziness
- □ Easily startled
- □ Excessive worry
- □ Excessive anger
- □ Excessive fear
- □ Fatigue/tiredness
- □ Headaches
- □ Loss of sleep/poor sleep
- □ Loss or gain of weight
- □ Nervousness/irritability
- □ Overwhelmed by life

Check conditions you have or have had in the past:

- □ AIDS
- □ Allergies
- □ Anemia
- □ Arthritis
- □ Bleeding disorders
- □ Breast lump
- □ Cancer
- □ Diabetes

How long has it been since you have had a complete medical exam? _____

HEALTH HISTORY…CONTINUED

Check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES

- □ Tremors or Cramps
- □ Swollen joints

Pain, weakness, numbness in:

- □ Arms or Hips
- □ Back or Legs
- □ Feet
- □ Neck
- □ Hands
- □ Shoulders
- □ Other_____

EYES/EAR/NOSE/THROAT/RESPIRATORY

- □ Asthma/wheezing
- □ Blurred or failing vision
- □ Difficulty breathing
- □ Earache
- □ Enlarged glands
- □ Eye pain
- □ Frequent colds
- □ Hay fever
- □ Hoarseness
- □ Gum trouble
- □ Nose bleeds
- □ Loss of hearing
- □ Persistent cough
- □ Ringing in ears
- □ Sinus problems

SKIN

- □ Boils
- □ Bruise easily
- □ Dry skin
- □ Itching/rash
- □ Sensitive skin
- □ Sore won't heal
- □ Sweats

GENITO/URINARY

- □ Blood/pus in urine
- □ Frequent urination
- □ Inability to control urine
- □ Kidney infection/stones
- □ Lowered libido

CARDIOVASCULAR

- □ Chest pain
- □ Hardening of arteries
- □ High or low blood pressure
- □ Pain over heart
- □ Poor circulation
- □ Previous heart attack
- □ Rapid/irregular heart beat
- □ Swelling of ankles

GASTROINTESTINAL

- □ Belching, gas or bloating
- □ Colon trouble
- □ Constipation
- □ Diarrhea
- □ Difficulty swallowing
- □ Distention of abdomen
- □ Excessive hunger
- □ Gall bladder trouble
- □ Hemorrhoids (piles)
- □ Indigestion
- □ Nausea
- □ Pain over stomach
- □ Poor appetite
- □ Vomiting

FOR MEN ONLY

- □ Erection difficulties
- □ Penis discharge
- □ Prostate trouble

FOR WOMEN ONLY

- □ Bleeding between periods
- □ Clots in menses
- □ Excessive menstrual flow
- □ Extreme menstrual pain
- □ Irregular cycle
- □ Menopausal symptoms
- □ PMS
- □ Previous miscarriage
- □ Scanty menstrual flow

Could you be pregnant?_____

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature_____ Date _____

Acupuncture Informed Consent

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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 Lindsay Fauntleroy, L.Ac. It also extends to 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 or any other office or clinic, whether signatories to this form or not.

I understand that methods 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 be 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, soreness, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. 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. Burns and/or scarring are a potential risk of moxibustion and cupping. 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, stomachache, 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 pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 that 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.

X_____

Patient Signature (Or Patient Representative) (Date)

_____

Print Name