Black Sheep Community Acupuncture, LLC

8441 Belair Rd #102 • Nottingham, MD 21236 • 443.900.2378

Health History Questionnaire & Registration Form

PATIENT INFORMATION	CONTACT INFORMATION
Date_____ Name_____ Address_____ City State Zip_____ Age_____ Birthdate _____ Preferred Pronoun _____ Occupation _____ How did you hear about us?_____	Cell phone _____ Home phone _____ Email _____ Another person we may contact if needed: Name _____ Relationship_____ Cell phone _____

HEALTH HISTORY	BSCA POLICIES
What are 3 symptoms you would like to resolve? 1- _____ 2 - _____ 3 - _____ How is your sleep? _____ _____ How is your digestion? _____ _____ List medications or food supplements you are taking. _____ _____ _____ _____ _____ List other important medical information such as serious illnesses, accidents or surgeries. (If pregnant, please indicate that here) _____ _____ _____ _____ _____	All payments are due at the time of service. We accept cash, check, Visa, MasterCard & Discover. If you need a receipt, please ask for one on the day of service. We do not provide back dated receipts, yearly statements or insurance codes. We do not provide primary care medicine. If you have an issue such as a serious infection, deep depression, or a wound that won't heal, we encourage you to see a medical doctor in addition to getting acupuncture. If you are experiencing any Covid, flu, or head cold symptoms, you may be contagious so please reschedule to keep others healthy. Please do not walk barefoot in the clinic. Though very rare, sometimes needles find their way to the floor. Always, double check that your acupuncturist has taken out all the needles before getting up to leave.

There is a $30 fee for appointments that are cancelled or missed with less than 24 hour notice.

Signature _____ Date_____

INFORMED CONSENT TO ACUPUNCTURE CARE

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 named 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, Tiu-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, 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 effect 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 or become 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 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.

PATIENT SIGNATURE X (Or Patient Representative)	(Indicate relationship if signing for patient)

OFFICE SIGNATURE