Loocie Brown Acupuncture
394 Lowell St., Suite 13
Lexington, MA 02420

Client Information Sheet

Please take time to fill out this questionnaire to the best of your ability. Please add details when relevant. All responses are kept confidential.

Your Name: _____ Best Phone to Reach You: _____
Date of Birth: _____ Email Address_____
Address: Street:_____
City:_____ State:_____Zip:_____

If Emergency Notify:_____ Phone:_____
Referred Through:_____
Are you a member of Blue Cross?_____Tufts?_____Other?_____
Is this your first time receiving Acupuncture? _____

The following questions regard your condition and general health.
Reasons for seeking treatment: Please list in priority
_____
_____
_____

History of problem(s): (length of time, severity, level of interference in activities)
_____
_____

Past Medical History (including significant illness, surgeries and/or injuries):
_____
_____
_____

Current Medications:_____

Coffee Use (# of cups daily):_____ Smoking (# of packs/day):_____
Alcohol Use (# of drinks daily):_____ Medical Marijuana (Y/N)_____

Exercise (type and # of days per week):_____

Typical Diet:	Morning	Afternoon	Evening
	_____	_____	_____
	_____	_____	_____

Consent to Treatment for Acupuncture & Adjunctive Therapies

I hereby request and consent to the procedure of acupuncture treatment(s) or other modalities sited below as appropriate to treatment on me (or on the patient named below, for which I am legally responsible) by the below name licensed acupuncturist and group clinicians.

I understand that treatment methods may include, but are not limited to: acupuncture, cupping, laser treatment, ear acupuncture, bloodletting, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese herbal medicine, CBD Oil and nutritional recommendations.

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. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist *immediately*.

I have been informed that I have a right to refuse any form of treatment at any time during the session. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I intend this consent form to cover the entire course of treatment for my health-related condition(s) and for any future conditions(s) for which I seek treatment.
_____Initials

I understand that there is a small chance, although rare, that bruising may result at the application sites with acupuncture or massage. In addition, there is a small chance, although rare, that my pain syndrome may be exasperated a day or so after treatment. In our experience, it is common that the condition will improve over the next 48 hours.
_____Initials

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation. _____Initials

_____

Patient's Name

_____

Patient's Signature **Date Signed**