

**Angela Boatright**  
Acupuncture Physician

**CONSENT FOR TREATMENT**

I, \_\_\_\_\_ hereby voluntarily request and consent to treatment methods used by Angela Boatright, Acupuncture Physician. I acknowledge and consent that such treatment methods may include but not be limited to: acupuncture, herbs, therapeutic massage, homeopathic remedies, nutritional and dietary recommendations. I also acknowledge and agree that the treatment methods are used for the purposes of “promotion, maintenance and the restoration of health and the prevention of disease.”

Signature of person being treated or guardian \_\_\_\_\_

Date \_\_\_\_\_

**PAYMENT POLICY AGREEMENT**

I, \_\_\_\_\_ understand that I am responsible for payment of services rendered at the time of treatment unless prior arrangements have been made for a different payment agreement. I also understand and agree to a charge of one-half (1/2) of the regular treatment fee for cancellation of an appointment less than 24 hours in advance of the scheduled treatment time.

Signature of person being treated or guardian \_\_\_\_\_

Date \_\_\_\_\_

# PATIENT INTAKE FORM

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Occupation \_\_\_\_\_ Referred by \_\_\_\_\_

In case of emergency notify \_\_\_\_\_

Relation to you \_\_\_\_\_

Phone number \_\_\_\_\_

Main concern for treatment \_\_\_\_\_

Date of original symptoms or injury \_\_\_\_\_

Have you been diagnosed Yes \_\_\_\_\_ No \_\_\_\_\_

What was the diagnosis? \_\_\_\_\_

Current medications \_\_\_\_\_

\_\_\_\_\_

Vitamins, minerals, herbs, etc... \_\_\_\_\_

\_\_\_\_\_

## FAMILY MEDICAL HISTORY

Diabetes? \_\_\_\_\_ Which relative? \_\_\_\_\_

High Blood Pressure? \_\_\_\_\_ Which relative? \_\_\_\_\_

Heart Disease? \_\_\_\_\_ Which relative? \_\_\_\_\_

Cancer? \_\_\_\_\_ Which relative? \_\_\_\_\_

Any other diseases not mentioned \_\_\_\_\_

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## DIETARY INFORMATION

Do you eat breakfast? \_\_\_\_\_ Lunch? \_\_\_\_\_ Dinner? \_\_\_\_\_

Coffee? \_\_\_\_\_ # of cups per day \_\_\_\_\_ Soft drinks? \_\_\_\_\_ # per day \_\_\_\_\_

Alcohol? \_\_\_\_\_ # per week \_\_\_\_\_ Do you smoke? \_\_\_\_\_ # per day \_\_\_\_\_

Water? \_\_\_\_\_ # of glasses per day \_\_\_\_\_

## DIGESTION

Do you have problems with belching? \_\_\_\_\_ Gas? \_\_\_\_\_ Bloating? \_\_\_\_\_

Constipation? \_\_\_\_\_ Diarrhea? \_\_\_\_\_ # of bowel movements per day? \_\_\_\_\_

Do you have burning urination? \_\_\_\_\_ Frequent urination? \_\_\_\_\_

Difficult urination? \_\_\_\_\_ Dribbling urine? \_\_\_\_\_ Kidney Stones \_\_\_\_\_

Do you have to wake up during the night to urinate? \_\_\_\_\_ # of times \_\_\_\_\_

## RESPIRATORY

Coughing? \_\_\_\_\_ How long? \_\_\_\_\_ Mucus? \_\_\_\_\_

Sore throat? \_\_\_\_\_ How long? \_\_\_\_\_

Asthma? \_\_\_\_\_

Allergies? (food, plant, animals, etc...) \_\_\_\_\_

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## **GYNECOLOGY**

Are you pregnant? \_\_\_\_\_ # of pregnancies \_\_\_\_\_ # of births \_\_\_\_\_

Date of last menstrual period? \_\_\_\_\_ # of days period lasts \_\_\_\_\_

How often do you menstruate? \_\_\_\_\_ Do you have heavy bleeding? \_\_\_\_\_

Clots? \_\_\_\_\_ Abdominal Cramps? \_\_\_\_\_ Back Cramps? \_\_\_\_\_

Do you have mood/feeling changes before? \_\_\_\_\_ During? \_\_\_\_\_ After? \_\_\_\_\_

Do you take birth control pills? \_\_\_\_\_ How long? \_\_\_\_\_

Have you had any miscarriages? \_\_\_\_\_ Infertility? \_\_\_\_\_

## **UROLOGY**

Problems with sex drive? \_\_\_\_\_ Impotence? \_\_\_\_\_

Enlarged prostate? \_\_\_\_\_ Premature ejaculation? \_\_\_\_\_

Infertility? \_\_\_\_\_ Difficulty in urination? \_\_\_\_\_

## **SLEEP**

Do you have difficulty falling asleep? \_\_\_\_\_ Staying asleep? \_\_\_\_\_

Excessive dreaming? \_\_\_\_\_ Nightmares? \_\_\_\_\_

Night sweats? \_\_\_\_\_

## **HEADACHES**

Do you have frequent headaches? \_\_\_\_\_ Migraines? \_\_\_\_\_

How often? \_\_\_\_\_ Which part of the head? \_\_\_\_\_

Dizziness? \_\_\_\_\_ Ear ringing? \_\_\_\_\_ Nausea? \_\_\_\_\_

