



LILAC
NATURAL
MEDICINE

Lilac Natural Medicine, LLC
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Acupuncture Intake

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Please describe the main problem you would like to have treated:

How long ago and under what circumstances did this problem begin?

To what extent does this problem interfere with your daily activities (work, sleep, exercise, emotions, etc.)? _____

Have you been given a medical diagnosis for this problem? If so, what?

What kinds of treatment have you tried? _____

Have you used Acupuncture or Naturopathic Medicine in the past? _____

Are you currently pregnant or trying to get pregnant? _____

Patient's Medical History

| | | | |
|---------------------|--------------------|--------------------------|-----------------------------|
| Hepatitis/HIV _____ | Diabetes _____ | Cancer _____ | Cardiovascular/Stroke _____ |
| Tobacco Use _____ | Thyroid _____ | Allergies/Asthma _____ | Substance Recovery _____ |
| Insomnia _____ | Chronic Pain _____ | Anxiety/Depression _____ | Headaches/Migraines _____ |

Are you currently taking any medications? If so please list: _____

List any vitamins or supplements you are taking: _____

Comments: _____

Acupuncture Informed Consent

I agree to receive Acupuncture treatments from Lilac Natural Medicine, LLC, which may include, but are not limited to the insertion of sterilized, disposable acupuncture needles into my body, the use of moxabustion, (a therapeutic herb), pressballs, ear seeds, cupping, heat lamp, electro-acupuncture, or the insertion of intradermal needles. I understand that each of these therapies will be explained to me before they are performed, and that I may verbally revoke my consent to receive any of these therapies at any time. I realized that no guarantee has been made regarding improvement or cure of my condition(s).

I understand that Acupuncture is a generally safe method of treatment, but, as with all types of healthcare, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns 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 nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although we use sterile disposable needles and maintain a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I understand that certain types of therapies are contraindicated if I become pregnant, and I will inform the provider if I am or become pregnant.

Patient Name

Date of Birth

Patient/Parent/Guardian Signature

Date