Dannielle Metcalf
Licensed Acupuncturist
751 East 36th Avenue Suite #102
Anchorage, Alaska 99503
907-929-7818, 907-929-7861 fax

Patient Information:

Patient Name _____

Address _____

City _____State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____Last 4#'s of SS# _____

Patients D.O.B. _____ Age _____ Gender _____

Occupation/Employer _____

Emergency Contact _____ Phone _____

Referral Source _____

Who is your primary care provider/MD? _____

Insurance Company _____

Policy Number _____ Group Number _____

Have you ever had acupuncture before? Yes ____ No ____

Chief Complaint(s):

Please identify your major health concerns

1._____

How long have you had this problem/concern? _____

2._____

How long have you had this problem/concern? _____

Have you been given a diagnosis for this problem/concern? _____

What other treatment have you tried and what were the outcomes?

Please list all medication, herbs and supplements you are currently taking.

Patient Name_____ DOB_____

Muscles / Bone / Joints

Do you have pain or tightness? _____ If yes, please indicate on the chart below.

The pain is (circle all that applies):

Sharp Dull Aching Numb Superficial Pain Burning Tingling

Shooting Deep Pain Pain worse in AM/PM Pain worse/better with heat

Pain worse/better with cold Pain worse/better with pressure

I have (circle all that apply):

Swollen joints Arthritis/joint pain Tendonitis Muscle cramping

Muscle pain Repetitive Strain Injury Bone Pain

Fractured Bone(s) _____ if yes, Where? _____

Please explain any injuries in the space provided:

Date of onset _____

Location _____

Duration of pain _____

What makes pain worse? _____

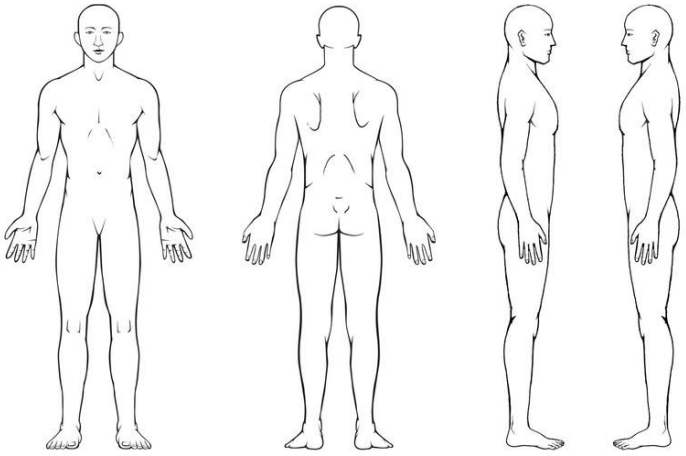
What makes the pain better (circle all that apply) heat cold massage movement rest

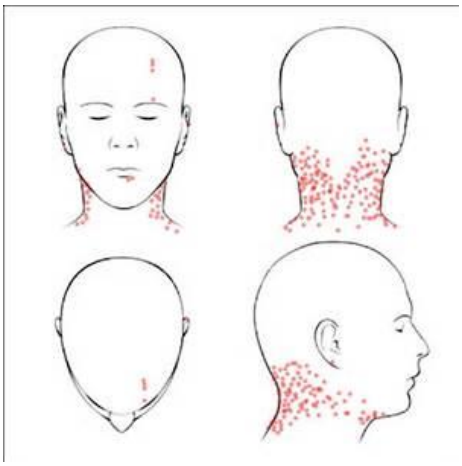
Treatments (ex. Ibuprofen, chiropractic) _____

What number best describes your pain now?

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

Please indicate areas of pain or distress on diagrams below:





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Consent for Treatment

I hereby authorize Dannielle C. Metcalf L.Ac. to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Acupuncture: insertion of special sterilized needle through the skin into underlying tissues at specific points on the surface of the body.
Cupping: a technique to relieve symptoms in which cups made of glass or other materials are placed on the skin with a vacuum created by heat or other device.
Gua Sha: a rubbing on an area of the body with a blunt, round instrument.
Herbs: may be given in the form of pills, powders, tinctures, pastes, plasters or other form such as raw herbs to be cooked. Cooked herbs may be given to take internally or externally as a wash. Herbal formulas may include shell, mineral, and animal materials.
Moxa: indirect burning on an acupoint using stick, string, or ball moxa to relieve symptoms.
Tuina: an ancient massage used to treat a wide variety of common disharmonies.
Dietary Advice: based on traditional Chinese Medical Theory.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: discomfort, pain, infection, or blistering at the site of the procedure; temporary discoloration of the skin; nausea, loose bowel movements, abdominal cramping; and aggravation of symptoms existing prior to the acupuncture treatment.
Potential benefits: drugless relief or presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem and the strengthening of the constitution.
Notice to Pregnant Women: Labor-stimulating acupuncture points are not used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment. All female patients must alert the intern or doctor if they know or suspect they are pregnant.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dannielle C. Metcalf, L.Ac, regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or if required or permitted by applicable law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of five, but no more than ten years after the date of my last treatment. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of her ability.

_____	_____
Guardian/Personal Representative's Name (PRINT)	Patient's Name (PRINT)
_____	_____
Guardian/Personal Representative's Signature	Patient's Signature Date
_____	_____
Relationship/Representative's Authority	Date

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Cancellation Policy

Our office requires that you call and cancel your scheduled appointment. Ideally at least one day prior to your schedule appointment if you will be unable to come. However we realize that emergencies do arise and the occasional same day cancellations do happen. In those cases calling as soon as possible will be taken into consideration. Please note that if you do not show up for your scheduled appointment and do not call to cancel you will be charged $50.00 (which is not billable to insurance).

This policy is in place so that patients in urgent need can be treated. The lack of a timely or no cancellation notification means that someone else who needs treatment does not have a chance to take advantage on the open time slot.

_____ _____

Guardian/Personal Representative's Name (PRINT) Patient's Name (PRINT)

_____ _____

Guardian/Personal Representative's Signature Patient's Signature Date

_____ _____

Relationship/Representative's Authority Date