

Cory Shaw, L.Ac.
Center for Complementary Medicine
7300 Blanco Rd, Ste. 503
San Antonio, TX 78216

Patient Information

Patient Name _____ D.O.B. _____
Last Name First Name M.I.
Address _____
City _____ State _____ Zip _____
Home Phone # _____ Work or Cell Phone # _____
Marital Status M S D W # of children _____ Occupation _____
Person responsible for your account _____ Have you received Acupuncture before? Y/N
Who may I thank for referring you? _____

Please read the information below and fill in any pertinent information but do not sign until your appointment

Request and Consent

I hereby request for Cory Shaw L.Ac. to treat me. I also authorize her to perform on me the treatment known as Acupuncture as her judgment may indicate and authorize her to use what ever therapeutic methods she may see fit, whether or not such methods are commonly and generally practiced in this community.

Cory Shaw has frankly and fully explained to me the nature and purpose of the treatment, the risks involved, the collateral hazards, and the possibilities of complications during or as a result of a treatment. I understand what the term "complications" means, and in giving my consent to the treatment, I have in mind her frank and full explanation. If any unforeseen condition arises in the course of the treatment and in the judgment of Cory Shaw it is advisable to use procedures in addition to or different from those now contemplated, I also request and authorize her to do whatever she deems advisable.

In the event that my condition is such that treatment is beyond the normal capacities of this clinic, I understand that I may be referred to other competent practitioners including, but not necessarily limited to, medical doctors or other acupuncturists.

If you are suffering from any of the following conditions, please notify the clinic at this time:

- | | | |
|--------------------------|--------------------------------|-----------------------------|
| 1. Heart condition _____ | 4. Fainting from needles _____ | 7. Hypertension _____ |
| 2. Stroke _____ | 5. Bruise easily _____ | 8. Hepatitis _____ |
| 3. Diabetes _____ | 6. Cancer _____ | 9. Infectious disease _____ |

I have been given no guarantee as to the results that may be obtained.

I agree to give 24 hours notice if I am going to be unable to make my scheduled appointment. I fully understand I will be charged the regular fee if I miss an appointment without giving 24 hours notice.

Signature of Patient or Guardian

Date

Cory Shaw, L.Ac.
Center for Complementary Medicine
7300 Blanco Rd, Ste. 503
San Antonio, TX 78216

Patient Name _____

Initial Health Status

Please describe the health condition for which you are seeking treatment:

When did the problem begin? _____

How often are your symptoms present? _____

What treatments have you sought for your condition? _____

Please list any other health problems you now have: _____

Please list any major disease or health problems in your family: _____

Please list any allergies, food sensitivities, or strong food cravings you now have: _____

Please list any accidents, surgeries, or hospitalizations (include date): _____

Please list any medications or supplements you are currently taking (include reason): _____

Please indicate the use and frequency of the following:

Tobacco _____ Coffee _____ Alcohol _____

Exercise _____

Please indicate any information you would like to share or feel is important to understanding your current health status, i.e. work-related stress, marital difficulties, etc.

Thank you for your time and honesty.