



**Associates For Creative Wellness, Inc. ®**

**Associates For Asian Healing Arts**

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**COMMUNITY ACUPUNCTURE CLINIC**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: (h) \_\_\_\_\_ (c) \_\_\_\_\_ EMAIL: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

IN CASE OF EMERGENCY: \_\_\_\_\_ PHONE: \_\_\_\_\_

*Please circle yes or no. If you answer yes to any question, please explain.*

- |     |    |   |
|-----|----|---|
| YES | NO | Have you ever had acupuncture?  |
| YES | NO | Do you frequently suffer from stress?                                   |
| YES | NO | Do you experience frequent headaches?                                   |
| YES | NO | Are you pregnant?   |
| YES | NO | Are you diabetic?   |
| YES | NO | Do you have high blood pressure?  |
| YES | NO | Are you taking any medication?  |
| YES | NO | Are you epileptic?  |
| YES | NO | Have you ever had surgery?  |
| YES | NO | Have you had any broken bones in the past two years?                    |
| YES | NO | Do you have tension or soreness in a specific area?                     |
| YES | NO | Do you have cardiac or circulatory problems?                            |
| YES | NO | Do you suffer from back pain?   |
| YES | NO | Do you have numbness or stabbing pain anywhere?                         |
| YES | NO | Are you very sensitive to touch/pressure in any area?                   |
| YES | NO | Do you have any other medical conditions I should be aware of ?         |
| YES | NO | Have you ever been in an accident or had a back, neck, or joint injury? |

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**Please take a moment and carefully read the following information and sign where indicated.**

I understand that the clinic acupuncture treatment I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the treatment may be adjusted to my level of comfort. I further understand that this should not be considered as a substitute for medical examination, diagnosis, or treatment. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to my changes in my medical profile, and understand that there shall be no liability on the practitioner's part should I forget to do so.

I understand that this office does not overbook appointments and that last minute cancellations or no shows cause a problem for the acupuncturist and for other patients and I agree to pay the full appointment fee for any appointments I miss without notifying the office at least **24 hours** before the schedule time.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_