



10150 City Walk Drive, Suite F Woodbury, MN 55129 ph 651-232-6830 / fax 651-232-6830 www.naturalcarewoodbury.com

NEW PATIENT INTAKE FORM

Patient Name: _____ Date of Birth: ____/____/____
(Last, First, Middle Initial) Gender at Birth _____

Preferred Gender and Pronouns _____

Address: _____

Phone: (C): _____ (H): _____ (W): _____

Email: _____ Social Security Number: _____

Primary Healthcare Provider and/or Clinic: _____

By checking the box to the right you consent to us communicating with your PCP if needed.

Who referred you to our clinic? _____

What is your reason for seeking care at our clinic? _____

When did your condition/symptoms begin? _____

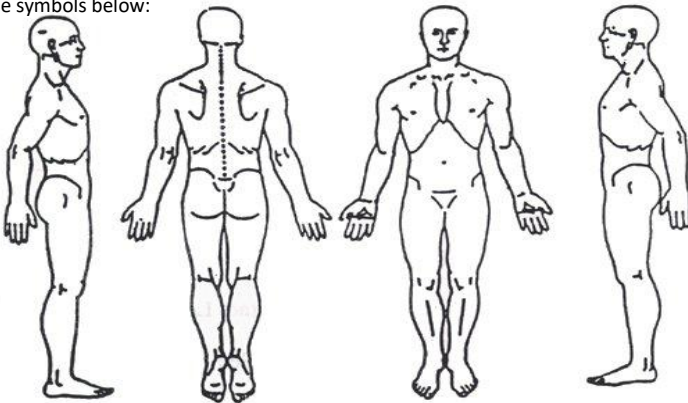
How did your condition/symptom begin? _____

How often do you experience you symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

Indicate on the picture below where you have pain or other symptoms, as well as the nature of your symptoms:

Use the symbols below:



- Numbness
=====
- Pins and Needles
00000000
- Burning
XXXXXXXXXX
- Stabbing
////////////////
- Aching
+++++++
- Other

1. During the past 4 weeks:

a. How much has pain interfered with your normal work (including work outside the home and housework)
 Not at all A little bit Moderately Quite a bit Extremely

b. How much of the time has your condition interfered with your social activities (like visiting with friends, relatives, etc.)
 All of the time Most of the time Some of the time A little of the time None

2. How are your symptoms changing?

Getting Better Not Changing Getting Worse

3. In general, would you say your overall health right now is:

Excellent Very Good Good Fair Poor

4. Who have you seen for your symptoms?

No one Chiropractor Medical Doctor Physical Therapist Other



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- a. What treatment did you receive and when? _____
 b. What tests have you had for you symptoms and when were they performed?

X-rays date: _____ CT Scan date: _____ MRI date: _____ Other date: _____

5. Have you had similar symptoms in the past? Yes No

- a. If you have received treatment in the past for the same or similar symptoms, whom did you see?
 This office Chiropractor Medical Doctor Physical Therapist Other

For each of the conditions listed below, place a check in the PAST column if you have had the condition in the past. If you presently have a condition listed below, place a check in the PRESENT column.

Past	Present		Past	Present		Past	Present
		Headaches			Heart Issues		
		Migraines			Stroke		
		Dizziness			Chest Pain		
							Cancer
		Spinal Pain			Kidney Disorders		Tumor(s)
		Upper Extremity Pain			Bladder Disorders		
		Lower Extremity Pain			Bladder Incontinence		Allergies
		Jaw Pain					Depression/Anxiety
					Liver Disorders		Thyroid Disorders
		Arthritis			Weight Gain/Loss		Epilepsy
		RA			GI Disorders		HIV/AIDS
		Autoimmune Disorder			Bowel Incontinence		Hepatitis
		Fatigue			Abdominal Pain		Skin Disorders

FAMILY HISTORY

Please list any serious health conditions (cancer, diabetes, heart conditions, autoimmune disorders, etc.) within your immediate family (mother, father, grandparents, brothers, sisters, etc.):

MEDICAL HISTORY

Please list any surgeries and their date(s): _____ Please list any trauma(s) or injuries and their date(s): _____

List current medications and herbs/supplements you are taking:

Medication/Supplement: _____ Dose: _____ Purpose: _____ Prescribed By: _____

Females only, please list:

Number of pregnancies: _____ Number of births: _____ Are you currently pregnant? Yes / No If yes, how many weeks? _____

PREVENTATIVE HEALTH HISTORY (Please circle health screenings performed within the last year)

Blood Pressure	Yes / No	Fasting Blood glucose	Yes / No
Breast Exam	Yes / No	Cholesterol	Yes / No
Pap Smear	Yes / No	Dental	Yes / No
Prostate Exam	Yes / No	Vision	Yes / No
Colonoscopy	Yes / No		

SOCIAL HISTORY

Alcohol Use Yes/No Drinks per week? _____ Caffeine Use Yes/No Drinks per day? _____ Tobacco Use Yes/No Type/Amount _____
 Exercise Yes/No Times per week? _____ Recreational Drug Use Yes/No Type _____ Dietary Restrictions _____



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

The Natural Care Center of Woodbury is committed to patient privacy and the confidentiality of the patient information/personal health information that is entrusted to us.

The ways in which we may use or disclose your health information are detailed in our Privacy Practices.

Your Right to Limit Uses or Disclosures:

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, we will provide you with a Limitation of Use and Disclosure of Protected Health Information Request form.

Your Right to Request that Your Patient Record be Amended:

You have the right to request that we amend the information in your patient record. If you would like to amend any information in your record, we will provide you with a Request to Amend Protected Health Information form.

Your Right to Revoke Authorization:

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

YOU HAVE THE RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUT YOUR CONSENT, HOWEVER, THE NATURAL CARE CENTER OF WOODBURY WILL NOT BE ABLE TO SUBMIT YOUR CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD PARTY PAYERS FOR PAYMENT, AND YOU WILL BE REQUIRED TO PAY CASH AT THE TIME OF SERVICE FOR ANY SERVICES RENDERED.

By signing below, I give consent to the Natural Care Center of Woodbury’s clinicians or staff to use or disclose my personal health information as stated in the Notice of Privacy Practices. I may request the full Notice of Privacy Practices at any time for review.

_____/_____/_____
(Signature of Patient) (Print Name) (Date)

_____/_____/_____
(Signature of Authorized Representative) (Date)



PATIENT FINANCIAL ACKNOWLEDGEMENT

Please read thoroughly. Initial your acknowledgements, then sign and print your name and the date. Thank you.

VERIFICATION OF BENEFITS

If you have medical insurance and would like to receive the maximum benefits available to you from your insurance company, it is important that YOU contact your insurance company PRIOR to your first visit in our office. We are happy to answer any insurance questions you may have, but please understand, The Natural Care Center can only assist you and CANNOT guarantee payment from your insurance company. Please note that it is your responsibility to understand your insurance benefits and coverage. Giving the Natural Care Center all of your insurance information, including any secondary insurances, will help us to estimate your benefits to the best of our ability.

ASSIGNMENT OF BENEFITS

I assign all benefits payable to me for my care at the Natural Care Center of Woodbury. I understand that this health care facility will be paid directly by the insurance company or other payer. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

GUARANTEE OF PAYMENT

I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility. I acknowledge that any exams not covered by insurance are due in full at the time of service. Your initials are a guarantee of payment for all charges incurred for treatment in accordance with the rates and terms of this health care facility. In the event that you have insurance coverage for chiropractic care and your diagnosis, but have an unmet deductible, the clinic may use the insurer's provided fee schedule to calculate your owed amount and collect a portion, or all, of your fee up front. In the event that payment cannot be made on the account and it is sent to collections, a 35% fee will be added to cover the cost of the collections agency. In the event that the clinic must take legal action against any persons with an outstanding debt, the patient is responsible for all legal and attorney fees.

APPOINTMENT FEES AND CANCELLATION POLICY

We require a \$50 deposit on all NP & EP Chiropractic, Acupuncture and Massage appointments to secure your time; Naturopathic appointments require a full amount deposit. This will be applied to your appointment/account or refunded if insurance pays in full for services. We require a 48-hour cancellation notification for our NP & EP Chiro and Acupuncture/Oriental Medicine, Massage, and Graston Therapy appointments; we require one business weeks' notice for Naturopathic appointment cancellation. Please note: a \$50 fee will be assessed for NP and EP Chiro, Acupuncture and Massage, and a \$25 fee for Graston cancellations made with less-than 48-hour notice, and the full deposit amount will be forfeited for naturopathic appointments without proper notice. Monday appointments must be cancelled on the Thursday prior to your scheduled visit to meet the 48-hour window. Credit card fees may apply for some cash services only, never for insurance-based visits or fees. Paying by cash, check or debit card avoids any fees.

ACUPUNCTURE COVERAGE

Your initial Acupuncture exam may, or may not, be covered. Please check with your insurance carrier about your specific plan and condition to ensure coverage. Even if your health plan covers general Acupuncture, your specific diagnosis may not be covered for treatment. If this is the case, you must pay out-of-pocket, but at a discounted rate for Acupuncture.

FOR ACUPUNCTURE AND CHIROPRACTIC MEDICARE PATIENTS

Acupuncture is not a covered service since licensed Acupuncturists are not able to credential with Medicare. We are not able to submit claims to them at any time. Also, Chiropractic examinations and re-examinations are never covered by Medicare. Your provider must do these to provide you with safe, accurate care even though they are not covered by the insurance. Medicare also does not cover therapies such as electric muscle stimulation, ultrasound, or traction. Please note: Medicare is your primary insurance carrier; this means that your supplement plan or secondary coverage will not pay the cost of these services even though they cover them. They only pay any additional costs after your primary insurance pays its portion.

_____/_____/_____
SIGNATURE (PATIENT/GUARDIAN) PRINT NAME DATE



NECK PAIN INDEX

Patient name _____

Date _____

This form is to be completed by patients being seen for neck pain. This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but please just circle the one choice which closely describes your problem right now.

Pain Intensity

- 0 I have no pain at the moment
1 The pain is very mild at the moment
2 The pain is moderate and does not vary much
3 The pain is fairly severe at the moment
4 The pain is severe but comes and goes
5 The pain is severe and does not vary much

Personal care (washing, dressing, etc.)

- 0 I can look after myself normally without causing extra pain
1 I can look after myself normally but it causes extra pain
2 It is painful to look after myself and I am slow and careful
3 I need some help but manage most of my personal care
4 I need help every day in most aspects of self care
5 I do not get dressed, wash with difficulty and stay in bed.

Lifting

- 0 I can lift heavy weights without extra pain
1 I can lift heavy weights, but it causes extra pain
2 Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table
3 Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
4 I can lift only very light weights
5 I cannot lift or carry anything at all

Reading

- 0 I can read as much as I want to with no pain in my neck
1 I can read as much as I want with slight pain in my neck
2 I can read as much as I want with moderate pain in my neck
3 I cannot read as much as I want because of moderate pain in my neck
4 I cannot read as much as I want because of severe pain in my neck
5 I cannot read at all

Headache

- 0 I have no headaches at all
1 I have slight headaches which come infrequently
2 I have moderate headaches which come infrequently
3 I have moderate headaches which come frequently
4 I have severe headaches which come frequently
5 I have headaches almost all the time

Concentration

- 0 I can concentrate fully when I want to with no difficulty
1 I can concentrate fully when I want to with slight difficulty
2 I have a fair degree of difficulty in concentrating when I want to
3 I have a lot of difficulty in concentrating when I want to
4 I have a great deal of difficulty concentrating when I want to
5 I cannot concentrate at all

Work

- 0 I can do as much work as I want to
1 I can only do my usual work, but no more
2 I can do most of my usual work, but no more
3 I cannot do my usual work
4 I can hardly do any work at all
5 I cannot do any work at all

Driving

- 0 I can drive my care without neck pain
1 I can drive my car as long as I want with slight pain in my neck
2 I can drive my car as long as I want with moderate pain in my neck
3 I cannot drive my car as long as I want because of moderate pain in my neck
4 I can hardly drive my car at all because of severe pain in my neck
5 I have no social life because of pain

Sleeping

- 0 My sleep is never disturbed by pain
1 My sleep is occasionally disturbed by pain
2 Because of pain I have less than 6 hours sleep
3 Because of pain I have less than 4 hours sleep
4 Because of pain I have less than 2 hours sleep
5 Pain prevents me from sleeping at all

Recreation

- 0 I am able to engage in all recreational activities with no pain in my neck at all
1 I am able to engage in all recreational activities with some pain in my neck
2 I am able to engage in most, but not all recreational activities because of pain in my neck
3 I am able to engage in a few of my usual recreational activities because of pain in my neck
4 Pain restricts me to short necessary journeys under 30 minutes
5 I cannot do any recreational activities at all

LOW BACK OSWESTRY 2.1A

Patient name _____

Date _____

This form is to be completed for patients being seen for back pain. This questionnaire is designed to give us information as to how your back (or leg) trouble affects your ability to manage in everyday life. Please answer every section. Mark one number only in each section that most closely describes you today.

Pain Intensity

- 0 I have no pain at the moment
- 1 The pain is very mild at the moment
- 2 The pain is moderate at the moment
- 3 The pain is fairly severe at the moment
- 4 The pain is very severe at the moment
- 5 The pain is the worst imaginable at the moment

Personal care (washing, dressing, etc.)

- 0 I can look after myself normally without causing extra pain
- 1 I can look after myself normally but it is very painful
- 2 It is painful to look after myself and I am slow and careful
- 3 I need some help but manage most of my personal care
- 4 I need help every day in most aspects of self care
- 5 I do not get dressed, wash with difficulty and stay in bed.

Lifting

- 0 I can lift heavy weights without extra pain
- 1 I can lift heavy weights, but it causes extra pain
- 2 Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table
- 3 Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- 4 I can lift only very light weights
- 5 I cannot lift or carry anything at all

Walking

- 0 Pain does not prevent me walking any distance
- 1 Pain prevents me walking more than one mile
- 2 Pain prevents me walking more than a quarter of a mile
- 3 Pain prevents me walking more than 100 yards
- 4 I can only walk using a stick or crutches
- 5 I am in bed most of the time and have to crawl to the toilet

Sitting

- 0 I can sit in any chair as long as I like
- 1 I can sit in my favorite chair as long as I like
- 2 Pain prevents me from sitting for more than 1 hour
- 3 Pain prevents me from sitting for more than half an hour
- 4 Pain prevents me from sitting for more than 10 minutes
- 5 Pain prevents me from sitting at all

Standing

- 0 I can stand as long as I want without extra pain
- 1 I can stand as long as I want but it gives me extra pain
- 2 Pain prevents me from standing for more than 1 hour
- 3 Pain prevents me from standing for more than half an hour
- 4 Pain prevents me from standing for more than 10 minutes
- 5 Pain prevents me from standing at all

Sleeping

- 0 My sleep is never disturbed by pain
- 1 My sleep is occasionally disturbed by pain
- 2 Because of pain I have less than 6 hours sleep
- 3 Because of pain I have less than 4 hours sleep
- 4 Because of pain I have less than 2 hours sleep
- 5 Pain prevents me from sleeping at all

Sex life (if applicable)

- 0 My sex life is normal and causes no extra pain
- 1 My sex life is normal but causes some extra pain
- 2 My sex life is nearly normal but is very painful
- 3 My sex life is severely restricted by pain
- 4 My sex life is nearly absent because of pain
- 5 Pain prevents any sex life at all

Social Life

- 0 My social life is normal and causes me no extra pain
- 1 My social life is normal but increases the degree of pain
- 2 Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport, etc.
- 3 Pain has restricted my social life and I do not go out as often
- 4 Pain has restricted social life to my home
- 5 I have no social life because of pain

Travelling

- 0 I can travel anywhere without pain
- 1 I can travel anywhere but it gives extra pain
- 2 Pain is bad but I manage journeys over two hours
- 3 Pain restricts me to journeys of less than one hour
- 4 Pain restricts me to short necessary journeys under 30 minutes
- 5 Pain prevents me from travelling except to receive treatment

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Score (X2) _____



The Keele STarT Back Screening Tool

Patient name _____

Date _____

Thinking about the **last 2 weeks** tick your response to the following questions:

	Disagree 0	Agree 1
1 My back pain has spread down my leg(s) at some time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
2 I have had pain in the shoulder or neck at some time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
3 I have only walked short distances because of my back pain	<input type="checkbox"/>	<input type="checkbox"/>
4 In the last 2 weeks, I have dressed more slowly than usual because of back pain	<input type="checkbox"/>	<input type="checkbox"/>
5 It's not really safe for a person with a condition like mine to be physically active	<input type="checkbox"/>	<input type="checkbox"/>
6 Worrying thoughts have been going through my mind a lot of the time	<input type="checkbox"/>	<input type="checkbox"/>
7 I feel that my back pain is terrible and it's never going to get any better	<input type="checkbox"/>	<input type="checkbox"/>
8 In general I have not enjoyed all the things I used to enjoy	<input type="checkbox"/>	<input type="checkbox"/>

9 Overall, how **bothersome** has your back pain been in the **last 2 weeks**?

Not at all	Slightly	Moderately	Very Much	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	0	0	1	1

Total Score (all 9): _____ **Sub Score (Q5-9):** _____



Patient Informed Consent for Chiropractic, Massage, and/or Acupuncture Services

I understand that I (or my minor child) am consenting to receive care that may include chiropractic adjustments and manual therapies, massage therapy, and/or acupuncture treatment. These services are intended to support musculoskeletal and general health through natural methods.

Chiropractic Care

Chiropractic treatment may include spinal manipulation, mobilization, soft tissue techniques, and other procedures. I understand that while chiropractic care is generally safe, risks include sprain/strain, rib fracture, disc injury, and in extremely rare instances, stroke from cervical spine manipulation. All reasonable precautions will be taken to prevent any such outcome.

Massage Therapy

Massage involves physical touch, pressure, and manipulation of muscles and soft tissues. Possible mild side effects may include soreness, bruising, or temporary discomfort. I will alert the therapist promptly if any pain or discomfort arises during the session. I understand that massage therapy may be accessed for relaxation or clinical purposes depending on how the patient presents. I understand a massage therapist will never touch genitals, breast tissue, or any other areas I instruct them not to touch.

I understand that the potential risks of massage therapy include: mild, short term muscle soreness due to movement of irritating metabolic wastes; mild surface level bruising. I understand I have the right to refuse massage therapy treatment at any time during the session.

I understand that I may be refused treatment if I appear obviously intoxicated or under the influence of drugs.

I authorize the performance of massage therapy techniques and procedures and understand that I will receive them from a certified massage therapist.

1. Name of Complementary and Alternative Health Care Practitioner:

O Natural Care Center of Woodbury, 10150 Suite F, Woodbury, MN 55129; 651-232-6830.

2. Education Level of Massage Therapists:

O All massage faculty have graduated from accredited massage therapy programs and are certified massage therapists.

THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIAL IS FOR INFORMATION PURPOSES ONLY.

Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other types of health care providers, the client may seek such services at any time.

3. As a complementary and alternative health care client, you have the right to file a complaint with the massage therapists' employer/supervisor. Any such complaint should be directed to the attention of the employer/supervisor, be in writing, and should include supporting details sufficient to permit an investigation into the complaint to commence.

4. Office of Complementary and Alternative Health Care Compliance (OCAP), Health Occupations Program: P.O Box 64882, St. Paul, MN 55164-0882; 651-201-3721. As a client, you may file complaints with such offices.

5. Massage is the systematic and scientific manipulation of the soft tissues of the body to prevent and alleviate pain, discomfort, muscle spasm and stress; and to promote health and wellness. Massage therapists utilize Western massage techniques from the Swedish tradition including: gliding, kneading, friction, vibration, percussion, and passive stretching, and depending on their training level, advanced techniques that address pain and dysfunction in the muscle and connective tissues. Relaxation Technique is defined as massage therapy modalities that have the intent of relaxation and general wellness. Two forms of Relaxation Technique are (1) Relaxation Technique provided for enjoyment with no clinical intent and (2) Relaxation Technique provided to produce a global



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outcome with clinical intent which the complexity of the case requires a higher level of critical thinking skills. Relaxation Technique modalities and methods utilized may include: Reflexology, Pregnancy Massage, Infant Massage, Geriatric Massage, healing Touch.

Clinical or Advanced Technique is defined as massage therapy modalities with clinical intent that require advanced training and highly skilled techniques for the purpose of meeting the patients' individual needs and are condition/injury/symptom related. The session is focused on 103 areas and coordinated within a clinical care plan that has specific short and long term goals. Clinical or Advanced Technique is often used to specifically aid in decreasing pain, increasing range of motion, and decreasing myofascial restrictions massage modalities/techniques with are more advanced and applied with a higher level of critical thinking may include: Manual Lymph Drainage, NeuroMuscular Therapy (NMT), Tigger Point Therapy, Myofascial Release, CranioSacral Therapy, and/or Reflexology.

6. Fees for massage therapy are based on increments of time and are scheduled in blocks of 30, 45, 60, and 90 minutes. Rates for these times vary respectively.
7. Payment is expected at time of service by cash, check or credit card for services not covered by insurance.
8. You have the right to reasonable notice of changes in services or charges.
9. You have the right to complete and current information concerning your assessment, recommended services to be provided, including the expected duration of the services to be provided.
10. You may expect courteous treatment and to be free from verbal, physical or sexual abuse by massage therapists.
11. Your records and transactions at the Natural Care Center of Woodbury are confidential, unless release of these records is authorized by you or as otherwise provided by law.
12. You have the right to be allowed access to records and written information from records in accordance with Section 144.335 of the Minnesota Statutes.
13. Other massage and bodywork services may be available to you in the community. Please ask for any information you would like.
14. You have the right to choose freely from available massage and bodywork practitioners and to change practitioners after services have begun, within the limits of health insurance or other health programs.
15. You have the right to coordinated transfer of your records when there will be a change in the provider of services. Your records will be transferred at your request.
16. You have the right to refuse services or treatment, unless otherwise provided by law.
17. You have the right to assert your right without retaliation from the massage therapists.

Acupuncture

Scope of Practice: Minnesota Law (Minnesota Statute 147B.06) defines Acupuncture practice as including, but not limited to, the following:

- Using Oriental medical theory to assess, diagnose and develop a plan to treat a patient in an attempt to improve overall body function and/or relieve pain
- Using treatment techniques that may include:
 - Insertion of sterile acupuncture needles through the skin
 - Acupuncture stimulation including, but not limited to, electrical stimulation or the application of heat with moxibustion or heat lamps
- Cupping
- Dermal friction
- Acupressure
- Herbal therapies
- Dietary counseling based on traditional Chinese medical principles
- Breath techniques or exercise according to Oriental medical principles

Possible Side Effects: I understand that there are possible side effects to my treatment that may include the following:

- Broken needles
- Minor pain or soreness in the treatment area
- Transient bruising
- Infection
- Needle sickness (dizziness, nausea, fainting)
- Sensation of heat, cold, tingling or numbness



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- Skin irritation or slight bleeding at needle sight
- Generalized fatigue
- Gastrointestinal disturbances from herbal remedies
- Minor burns from moxibustion (heat stimulation)

I understand and have been allowed access to upon request, following before or during my initial visit:

- The acupuncturist’s qualifications: education, licensure, and scope of practice;
- Possible side effects, including pain, bruising, infection, “needle sickness,” or broken needles.
- I certify that I have been asked whether I’ve been examined by a licensed physician or other professional regarding my presenting complaint, and that the provider has reviewed that information.
- I have been advised to consult with my primary care physician when indicated, and I acknowledge this.
- I have been asked about pacemaker use or bleeding disorders.
- I understand sterilized equipment meeting CDC standards will be used, and my acupuncturist will maintain appropriate records, including documentation of this consent and my medical history

Your Rights

Voluntary Consent: I understand consent is voluntary and may be withdrawn at any time.

Disclosure of Treatment Options

I have been informed of my right to ask questions, decline treatments, or request modifications.

Minor Consent

If I am the parent/legal guardian, I confirm my authority to consent for the minor and understand the associated risks and benefits.

I acknowledge that in Minnesota, certain minors (e.g., 16+ or those legally deemed "mature minors") may consent to specific treatments independently. I confirm that I have disclosed any such applicable situation.

- I consent to voicemail or phone messages about my care or my minor child’s care being left at the number provided.

By signing, I acknowledge I have read and understand the information above, have had access to my clinician to ask questions, and consent to treatment.

Signature of Patient or Guardian _____
Date

Printed Name _____
Provider Signature _____
Date

Clinician Only Below

Based on my personal observation, the patient’s history and physical exam, I conclude that throughout the informed consent process the patient was:

- Of legal age**
- Appears unimpaired**
- Consent given through guardian**
- Oriented X3**
- Fluent in English**
- Assisted by a translator/interpreter**

**** For Acupuncture Only ****

Do You Have A Bleeding Disorder? Yes No
Do You Have A Pacemaker? Yes No