

## I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

I, the undersigned, do affirm that I have been advised by Noran Malouf L.Ac to consult a physician regarding the condition for which I am seeking treatment..

## II. INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I consent to acupuncture treatments and other procedures associated with Traditional Oriental Medicine. I understand that methods of treatment may include but are not limited to acupuncture, moxabustion, cupping, electrical stimulation, and Tui Na (Chinese Massage), herbal medicine, nutritional counseling, and lifestyle adjustments.

I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infections, and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after the cupping. Burns and/or scarring are a potential risk of moxabustion.

The herbs and nutritonal supplements (which are from plant, animal, and mineral sources) that have been recommended are considered safe. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives, and tingling of the tongue. I will notify the acupuncturist if I am or become pregnant. I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbal tea or supplements.

I understand the acupuncturist may review my medical records and that portions of my records may be used for teaching or research purposes; however, my name and identifying information will not be disclosed. Otherwise, all of my records will be kept confidential and will not be released to any party without my written consent.

## III. OFFICE POLICY

We value your time, and we pride ourselves on keeping your wait to a minimum. We understand travel in Manhattan can be challenging and we will accommodate late arrivals the best we can. While most practitioners treat multiple patients at the same time, I specialize in focusing upon only one patient per hour (unless there's an emergency) Please recognize that the entire time has been exclusively appointed to you. Therefore we appreciate that all scheduling changes be made with as much advanced notice as possible. Please notify us by 12:00 noon on the day before your appointment. For clients wishing to have extended treatments (2 hours or more) please notify us by 12:00 noon 3 days prior to your appointment. . Failure to follow the policies will result in a charge to your account for the full amount of the treatment (with the exception of medical, trauma or family emergencies). If another client fills your appointment you will not be billed for the missed appointment.

If you have health insurance, we will provide you with a detailed receipt for your paid visit, which you will then use to submit to your insurance carrier, or accountant.

**By voluntarily signing below I show that I have read, or have had read to me, the office policy and consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.**

**To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated.)**

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Print Name of Acupuncturist

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Signature of Acupuncturist

\_\_\_\_\_  
Print Name of Patient Representative

\_\_\_\_\_  
Date Consent Completed

# Pediatric Intake

Child's name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: Male / Female

Guardian's Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Who is filling out this form (name and relation)? \_\_\_\_\_

## Contacts

\*Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

\*Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

\*Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Who does the child live with? \_\_\_\_\_

Other health care providers:

1. \_\_\_\_\_ Phone: \_\_\_\_\_

2. \_\_\_\_\_ Phone: \_\_\_\_\_

3. \_\_\_\_\_ Phone: \_\_\_\_\_

What are your child's health concerns, in order of importance:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

## Medical History

How would you describe your child's general state of health? Excellent Good Fair poor

Please indicate any serious conditions, illnesses, or injuries, and any hospitalizations, along with approximate dates:

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Does your child have any allergies (medicines, environmental)?

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Please list all current medications (prescriptions, over-the-counter, vitamins, herbs, etc.)

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How many times has your child been treated with antibiotics? \_\_\_\_\_

Please indicate which immunizations your child received:

\_\_\_\_\_ DPT (diphtheria, pertussis, tetanus)    \_\_\_\_\_ Flu    \_\_\_\_\_ Haemophilus influenza B  
\_\_\_\_\_ Hepatitis A    \_\_\_\_\_ Hepatitis B    \_\_\_\_\_ MMR (measles, mumps, rubella)  
\_\_\_\_\_ Polio    \_\_\_\_\_ tetanus booster; when: \_\_\_\_\_

Other: \_\_\_\_\_

Any adverse reactions to vaccination? \_\_\_\_\_

What screening tests has your child had (blood, hearing, vision, etc): \_\_\_\_\_

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### **Prenatal health**

How would you describe the health of the parents before conception?

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

How would you describe the health of the parents at conception?

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

How would you describe the health of the parents during pregnancy?

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

What was the mother's age at childbirth? \_\_\_\_\_

Did the mother receive any prenatal medical care? \_\_\_\_\_

Did the mother experience any disease during pregnancy (hypertension, diabetes, bleeding, trauma, stress)? \_\_\_\_\_

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Did the mother use any of the following during pregnancy?

\_\_\_\_\_ Tobacco (first & second hand)    \_\_\_\_\_ Alcohol    \_\_\_\_\_ Recreational drugs    \_\_\_\_\_ Supplements

\_\_\_\_\_ Prescription medications    \_\_\_\_\_ Over the counter medications

Other: \_\_\_\_\_

### **Birth History**

Term length \_\_\_\_\_ Weeks. Length of labor: \_\_\_\_\_ Weight at birth: \_\_\_\_\_

Complications: \_\_\_\_\_

Was the birth: \_\_\_\_\_ Vaginal, \_\_\_\_\_ C-Section, \_\_\_\_\_ Induced, \_\_\_\_\_. Anesthesia: Yes / No

Other pertinent information: \_\_\_\_\_

**Family History.** Please list any pertinent information regarding your family's health history.

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**Diet**

Was your infant breast-fed? \_\_\_\_\_ If yes, for how long: \_\_\_\_\_  
What types of formulas did you use: \_\_\_\_\_  
\_\_\_\_\_

What foods were introduced before 6 months? \_\_\_\_\_  
\_\_\_\_\_

What foods were introduced between 6 months- 12 months? \_\_\_\_\_  
\_\_\_\_\_

Please list your child's food allergies / intolerances: \_\_\_\_\_  
\_\_\_\_\_

Does your child have any restrictions (religious, vegan, etc.)? \_\_\_\_\_  
\_\_\_\_\_

Please fill out the Daily Record of Food Intake.

**Environment**

Is the child in \_\_\_school \_\_\_daycare \_\_\_homecare \_\_\_other: \_\_\_\_\_

What are your child's favorite activities? \_\_\_\_\_  
\_\_\_\_\_

Please describe the frequency and type of exercise: \_\_\_\_\_  
\_\_\_\_\_

How much television does your child watch? \_\_\_\_\_Hrs/ wk.

Does anyone in the house smoke / drink? \_\_\_\_\_ Pets? \_\_\_\_\_

Do you know of any toxins or other hazards that your child is regularly exposed to? \_\_\_\_\_  
\_\_\_\_\_

How would you describe the emotional climate at home? \_\_\_\_\_  
\_\_\_\_\_

How would you describe your child's temperament? \_\_\_\_\_  
\_\_\_\_\_

How would you describe your child's behavior at school/ daycare? \_\_\_\_\_  
\_\_\_\_\_

Is there anything that you feel is important that has not been covered? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_