Dawn Lucia, L.Ac., M.Sc.O.M.
Acupuncture & Herbology Ltd.
75 Papawai Road, RD 1, Greytown, New Zealand 5794
06 304 8300
e:drlucia@xtra.co.nz / www.acuherb.co.nz

PATIENT REGISTRATION FORM
PERSONAL HISTORY

Dear Patient: This information is considered confidential. Please be as neat and accurate as possible while completing this form. Thank you. **PLEASE PRINT CLEARLY**.

Name:_____
(Given name) (Middle initial) (Family name)

Address:_____
(Include street type, such as St., Ave., Rd., etc.) (Suburb) (City)

Date of Birth: Date _____ Month_____ Year _____

Mobile Phone #:_____

Home Phone #:_____**Work Phone # _____**

Personal E-mail address:_____

May we send quarterly Newsletters? _____Yes _____No

Occupation_____**Sex: _____ M or _____ F**

Marital Status:_____
(Single, Married, Domestic Partner, Divorced or Widowed)

Who referred you to our office? _____

May we contact this person to say thank you? ____Yes or ____No

Please describe the principal health problems and the duration of these conditions for which you came to this office:

_____
_____
_____

What are your treatment goals?

_____
_____
_____

INFORMED CONSENT FOR ACUPUNCTURE AND ORIENTAL MEDICINE TREATMENT AND CARE

Name and Address of Clinic/Office:
Acupuncture & Herbology Ltd.
75 Papawai Road, RD 1
Greytown, New Zealand 5794
06 304 8300

Name of Acupuncturist treating this Patient:
Dawn Rene Lucia, L.Ac.

Print Patient's Name:_____

I hereby request and consent to the performance of procedures which are within the scope of practice of acupuncture and oriental medicine including, but not limited to, acupuncture, moxibustion, cupping, electro acupuncture, Herbology, and various modes of therapies on me (or on the patient named above, for whom I am legally responsible) by the acupuncturist named above.

I will have an opportunity to discuss with the acupuncturist or clinic personnel the nature and purpose of acupuncture, moxibustion, cupping, electro-acupuncture, Herbology, and various other therapies. I understand that results are not guaranteed.

I understand and am informed that there are some risks to acupuncture and oriental medicine treatment, including, but not limited to, slight bruising, tingling near the needling sites that last a few days, nausea, infection, and blisters. There have been instances reported of spontaneous miscarriage and pneumothorax. I understand that some herbs may be inappropriate during pregnancy. If I suspect I am pregnant, I will immediately inform the acupuncturist. If I experience any gastro-intestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests

Signature of Patient or Patient's Representative: _____

Print Name of Patient's Representative: _____

Relationship or Authority of Representative: _____

Acupuncture & Herbology Ltd.
Dawn Lucia, L.Ac., M.Sc.O.M.
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FEES, CASH AND PAYMENT AGREEMENT FOR ACUPUNCTURE AND ORIENTAL MEDICINE CARE

Welcome to our office. We hope that you find our office and staff pleasant.

CANCELING OR CHANGING APPOINTMENTS:

We will set a specific course of treatment for you. A certain number of treatments in a set amount of time are required to get the desired results. If you need to change an appointment, be sure to make up the missed appointment within a week.

If, for some reason you need to cancel your appointment, please call ahead and let us know so that we may accommodate another patient at that time. ***A no show or cancellation without notice at least 24 hours prior to scheduled appointment will result in a charge at our full rate.***

UPSETS:

We are here to serve you. Please feel free to speak with the clinic manager about any upsetting matter.

FEES:

Method of payment accepted is cash or EFTPOS. If our clinic does not get reimbursed from ACC, you are fully responsible and liable for all charges of services. For your information, some of our fees are as follows:

GENERAL

Initial Consultation with 1st Acupuncture Treatment	$ 130.00
Acupuncture treatments after the above	$ 90.00

ACC

Initial Consultation with 1st Acupuncture Treatment	$ 72.00
Acupuncture treatments after the above	$ 32.00

Herb Formulas/Vitamins/Minerals (will be discussed prior to dispensing)

_____ _____

Patient's Signature **Date**

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Please indicate for each of the questions below, your experience by use of one of the following codes.

Codes: Leave blank for Never had 2 for in Past 3 for Presently have

MUSCULO-SKELETAL SYSTEM
_____Arm Problems
_____Low Back problems
_____Leg problems
_____Swollen joints
_____Painful joints
_____Stiff joints
_____Sore muscles
_____Weak muscles
_____Walking problems
_____Ruptures of tendons
_____Broken bones
_____Pain between shoulders

GENITO-URINARY SYSTEM
_____Bladder trouble
_____Excessive urine
_____Scanty urine
_____Painful urine
_____Discolored urine

FEMALE
_____Menstrual problems
_____Vaginal discharge
_____Vaginal pain
_____Breast pain
_____Lumps on breast

MALE
_____Prostate problems

GASTRO INTESTINAL SYSTEM
_____Poor appetite
_____Excessive hunger
_____Excessive thirst
_____Difficulty chewing
_____Difficulty swallowing
_____Nausea
_____Vomiting food
_____Vomiting blood
_____Abdominal pain
_____Diarrhea
_____Constipation
_____Black stool
_____Bloody stool
_____Hemorrhoids
_____Liver trouble
_____Gall Bladder problems
_____Weight gain/loss

CARDIO-VASCULAR RESPIRATORY
_____Chest pain
_____Heart pain
_____Rapid heart beat
_____Blood pressure high
_____Blood pressure low
_____Heart problems
_____Difficult breathing
_____Persistent cough
_____Coughing up phlegm
_____Coughing up blood
_____Lung problems
_____Varicose veins

NERVOUS SYSTEM
_____Numbness
_____Paralysis
_____Dizziness
_____Fainting
_____Headaches
_____Muscle jerking
_____Convulsions
_____Forgetfulness
_____Confusion
_____Depression
_____Anxiety

EYE, EAR, NOSE AND THROAT
_____Eye strain
_____Eye inflammation
_____Vision problems
_____Ear pain
_____Ear noises
_____Hearing loss
_____Ear discharge
_____Nose pain
_____Nose bleeding
_____Nose discharge
_____Sore gums
_____Dental problems
_____Sore mouth
_____Sore throat
_____Hoarseness
_____Difficult speech
_____Difficult breathing through nose

Signature:_____Date:_____