white peony
acupuncture

Sarah White Stillman, L.Ac, MSOM
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3775 Iris Ave #3B
Boulder, CO 80301

whitepeonyacu.com

Name:_____ Date: _____

Phone (h): _____ (w): _____ (c): _____

Email address: _____ Occupation: _____

Address: _____

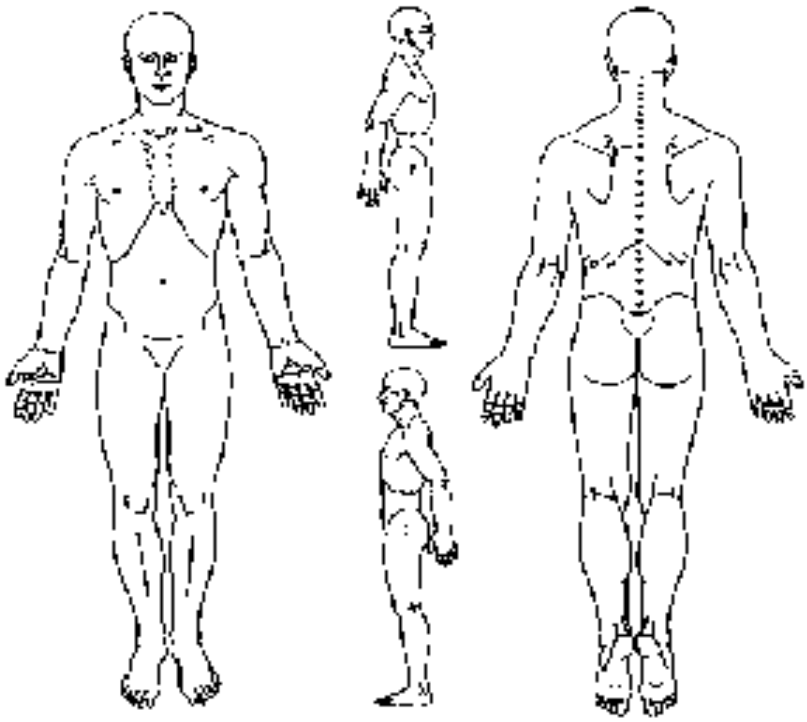
Date of Birth: _____/_____/_____ Age:____ Gender: M F Referred by: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Please identify the health concerns in order of importance:

Current medications and supplements:

On the figure to the right please indicate areas of pain (with x's) and level of pain from 1-10.



sarah@whitepeonyacu.com

Do you have any medical diagnoses or simply areas of concern or areas to be improved upon in the following systems:

Digestive (including elimination, urination and bowels)

Immune (including autoimmune conditions)

Sleep

Endocrine/hormones (including reproductive)

Mental health (including general stress to trauma. How do you describe yourself emotionally?)

Cardiac (including circulation)

Respiratory (including allergies and skin)

Skeletal (including any injuries or surgeries and associated dates)

Nervous system (including brain and cognitive function)

Any hospitalizations (date and reason)?

Other:

Consent to Receive Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or other modalities from the Oriental Materia Medica by Sarah W. Stillman, licensed acupuncturist. I understand that acupuncturists practicing in the state of Colorado are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin. Moxa is the application of heat at certain points on or near the surface of the body. These modalities treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that direct moxibustion as part of therapy, carries with it the risk of burning or scarring. I understand that I am able to refuse this therapy.

Chinese Herbs: I understand that substances from the Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that it is my decision to take these substances and I must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call White Peony Acupuncture as soon as possible.

Cupping and Shiatsu/Tui-Na Massage: I understand that I may receive cupping and shiatsu/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if I choose.

Electro-Acupuncture: I understand that I may be given the option to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

Fee Schedule:

Initial 90-minute exam and treatment	$165
Follow-up treatments (1 hr)	$110
House Calls (Initial 90-minute)	$195
House Calls (1 hr Follow up)	$165
Pediatric 0-12 yrs (Initial 1 hr)	$110
Pediatric 0-12 yrs (Follow up 30-45 min)	$85
Cosmetic acupuncture (1 hr)	$140
Cosmetic acupuncture (90 min)	$180

Cancellation Policy:

Please provide at least 24 hours notice if you need to change or cancel an appointment. There will be a charge for missed appointments or for cancellations made within less than 24 hours of the appointment time.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Printed Name: _____ Date of Birth: ____ /____ /_____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: _____

Signature: _____ Date: ___/___/_____