Mark Shprintz
Licensed Acupuncturist
Nashville Healing Arts, Inc
Initial Patient Consultation

953 Main Street
Nashville, TN 37206
(615) 830 4700

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ E-Mail: _____

Date of Birth: _____ Age: _____ Occupation: _____

Emergency Contact and Number:_____

Referred by: _____

Primary Issue / Main Complaint: (Please describe its location, symptoms, duration and any previous medical diagnosis. Include any associations you may have regarding its onset or recurrence.)

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Comments: Please inform me of any other issues you would like to discuss.

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Please list all **Prescription Medications and Supplements** you are currently taking and health issues they address.

Acupuncture Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other optional procedures including electro-acupuncture, vacuum cupping and acupressure massage on me (or on the patient named below, for which I am legally responsible) by Mark Shprintz, Licensed Acupuncturist.

Although all necessary precautions are made to make my acupuncture as safe and comfortable as possible I am aware that certain adverse reactions 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.

The herbs and nutritional supplements that are recommended are considered safe in the practice of Chinese Medicine but I understand there are possible adverse reactions including gastrointestinal upset, headaches , nausea or possible aggravation of symptoms. Some herbs may be inappropriate during pregnancy and I will inform my practitioner of my pregnancy status. I understand it is my responsibility to inform my acupuncturist of changes in prescription medications or health status.

I understand that although acupuncture and herbal medicine may be effective treatment for many health conditions it does not replace the need for evaluation, diagnosis and treatment by a Medical Doctor.

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation.

I agree to pay all charges incurred for services rendered, over and above insurance coverage.

Patient Signature **Date**

Patient Name_____

Date_____

Indicate on the drawing the location of your pain or discomfort. Use heavy lines to show fixed pain and dotted lines to show radiation or intermittent pain.Circle areas of generalized discomfort.
If your pain moves around or affects multiple locations label them 1, 2, 3, etc. in terms of severity with #1 as the most severe.