Leona K. Marrs M.S., L.Ac.
Acupuncture and Chinese Herbal Medicine
3542 Hollydale Dr., Los Angeles, CA 90039
206.383.6746
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ACUPUNCTURE AND ORIENTAL MEDICINE INFORMED CONSENT FOR TREATMENT

I, ____, hereby authorize Leona K. Marrs M.S., L.Ac. to perform the following specific procedures as necessary to facilitate my diagnosis and treatment.

Acupuncture: insertion of special sterilized needles through the skin into underlying tissues at specific points on the surface of the body.

Cupping: a technique to relieve symptoms in which cups made of glass or other materials are placed on the skin with a vacuum created by heat or other device.

Gua Sha: a rubbing on an area of the body with a blunt, round instrument.

Herbs: may be given in the form of pills, powders, tinctures, pastes, plasters, or other forms such as raw herbs that require cooking. Cooked herbs may be given to take internally or externally as a wash. Herbal formulas may include shell, mineral, and animal materials.

Moxa: indirect burning on an acupoint using stick, string or ball moxa to relieve symptoms.

Tuina: an ancient massage used to treat a wide variety of common disharmonies.

Dietary advice: based on traditional Chinese Medical theory.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: discomfort, pain, infection, or blistering at the site of the procedure; temporary discoloration of the skin; nausea, loose bowel movements, abdominal cramping; and aggravation of symptoms existing prior to the acupuncture treatment.

Potential benefits: drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem and the strengthening of the constitution.

Notice to Pregnant Women: I do not use labor-stimulating acupuncture points unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment. All female patients must alert the intern, doctor, or practitioner if they know or suspect they are pregnant.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Leona K. Marrs M.S., L.Ac., The Art of You, or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or if it is required by law. I understand that I may look at my medical record at any time and can request a copy of it. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last treatment. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any question I have will be answered by my practitioner to the best of her ability.

______________________	______________________
Date	Signature of Patient
______________________	______________________
Date	Signature of Patient Representative or Guardian
______________________	______________________
Date	Signature of Practitioner

Original to: Chart
Copy to: Patient (if requested)

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PATIENT PROFILE

Date ____________________

Last Name ______________________________ First Name ______________________________

Birth date ____________ Phone ___________________ Email ________________________

Address ____

Sex _________ Occupation ____________________ Employer ________________________

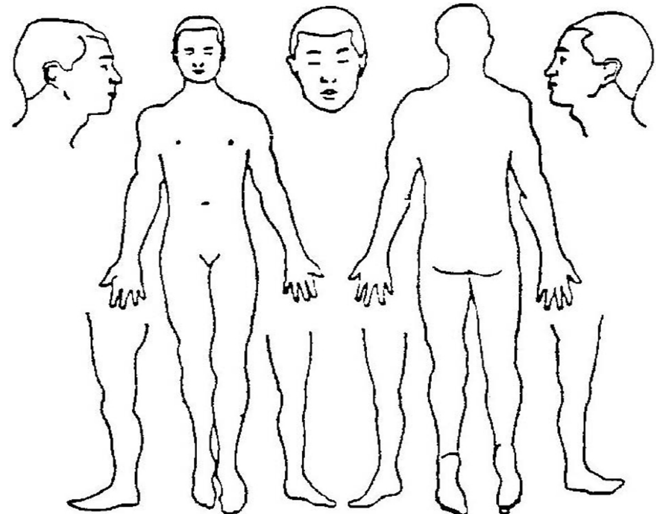
Emergency Contact Name and Phone number ____

A note to my patients: Please complete this two-sided questionnaire as thoroughly as possible in order to help me in your diagnosis and treatment. This is a confidential record of your medical treatment and will not be release, except when you have provided us with written authorization to do so. Thank you

PRESENT HEALTH CONCERNS

Please list your most important health concerns in their order of significance as well as any related diagnoses and treatments you have tried:

Please indicate any painful areas:



What goals do you have for your visit at the clinic today?

Have you ever consulted a Naturopathic physician, Acupuncturist, Nutritionist or a Counselor before?

Do you have any questions about this clinic or the care you've chosen today?

Please list prescription medications that you are currently taking, with dosages:

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages:

Allergies (drugs, chemicals, foods/result):

PERSONAL HABITS

Please circle any of the following substances you use regularly:

Tobacco   Coffee/black tea/cola

Alcohol   Recreational drugs

Do you follow any particular diet regimens or restrictions? If yes, please describe:

Do you exercise regularly?

What type?

How long?

How often?

PAST HISTORY

Hospitalizations/Surgeries (type and date):

Significant Trauma (falls, auto accidents, etc.):

Date of last physical/annual exam:

Date of last blood tests:

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Have you ever been treated for substance abuse?

PERSONAL AND FAMILY HISTORY

Please check any conditions that apply to you or one of your family members and note to whom it applies. Also please indicate whether it is a current problem or a past problem.

Alcoholism/Drug	Epilepsy
Addiction	Headaches
Allergies	Heart Disease
Anemia	Hepatitis
Arthritis	High Blood Pressure
Asthma	HIV
Cancer	Kidney Disease
Depression	Mental Illness
Diabetes	Stroke
Eczema	Tuberculosis
STDs	Other

SOCIAL HISTORY

Please circle your status: Single Significant Other

Do you have any children?

If yes, please list their ages:

COMMENTS (any other problems you would like to discuss):