Dakota
Natural Health Center

Today's Date: _____ Date of Birth: _____

Name (first, middle initial, last):_____

Address:_____

City: _____State: _____ Zip Code:_____ Sex/Gender: M / F

CELL phone #: _____ Alternate#: _____

** *Can we contact you/confirm appointments via TEXT messaging?* YES / NO

Email address: _____** *Can we email you?* YES / NO

Emergency Contact:_____Phone:_____

How did you hear about us? _____

I have read/been given the HIPAA pamphlet **(please sign):** _____

Pertinent Health History

Primary Reason for Today's Appointment: _____

_____

Has this problem been evaluated/diagnosed by a primary care provider? YES / NO

Please list ALL your medications/dosages AND supplements/vitamins:

_____

_____

_____

_____

Do you have any of the following (check the box for YES):

____ History of blood clots, bleeding disorders or clotting disorders

____ Current or history of blood-born infection/disease

____ Surgically implanted devices, joint replacements, surgical "hardware"

____ Hypertension, diabetes, low blood sugar, easy fainting or bruising

Are you pregnant, trying to conceive or nursing/lactating? YES / NO

Are you taking blood thinning medications? YES / NO

Dakota
Natural Health Center

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701.258.9418| 800.290.7028
www.dakotanaturalhealthcenter.com

INFORMED CONSENT FOR ACUPUNCTURE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of naturopathic medicine on me (or on the patient named below, for whom I am legally responsible) by ***The Doctor of Naturopathic Medicine*** ("the doctor") and/or other Doctors of Naturopathic or Oriental Medicine or Licensed Acupuncturists (LAc) who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctors, including those working at the clinic or office listed below or any other office of clinic, whether signatories to this form or not.

There are some risks to treatment, including but not limited to some bruising of the skin and/or slight bleeding, pneumothorax and organ puncture. The risk of infection is small when all needles are sterile. Needles are considered sterile when they are single use/disposable. No needle autoclaving is performed by this doctor/facility; all needles are single use/disposable.

I have had an opportunity to discuss with the doctor the nature and purpose of acupuncture. I understand that results are not guaranteed.

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

I understand that I have the choice to accept or reject the proposed diagnostic procedure or treatment, or any part of it, before or during the diagnosis or treatment.

I understand that the doctor is not providing primary (allopathic) medical care, and that I should look to my primary care provider (i.e. MD, NP, etc.) for those services and for routine check-ups.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent for to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient/Guardian Printed Name Date

_____ _____

Patient/Guardian Signature Date