Sara Kendall Gordon, L. Ac. DAOM
Doctor of Acupuncture and Oriental Medicine
Integrative Medicine and Optimal Health

Patient Information Form

Today's Date_____ **Name You Preferred To Be Called**_____

Legal First Name _____ **Middle Initial** ___ **Last Name**_____

Street Address_____ **City**_____ **State**_____ **Zip Code**_____

Mailing Address (if different)_____ **City**_____ **State**_____ **Zip Code**_____

Birth Date _____ **Sex** ☐ Male ☐ Female **Marital Status** ☐ Single ☐ Married ☐ Other_____

Home Phone (_____) ___-_____ Work Phone (_____) ___-_____ Cell Phone (_____) _____-_____

E-Mail Address_____

Language_____ **Race**_____ **Ethnicity**_____ **Height** _____ **Weight**_____

Employer's Name_____

Street Address_____ **City**_____ **State**_____ **Zip Code**_____

Occupation_____ ☐ **Full-Time** ☐ **Part-Time**

Emergency Contact Name:_____ **Phone Number (_____) _____-_____**

Relationship To You_____ **Referred by**_____

Were you injured at work? ☐ Yes ☐ No **Were you involved in any other type of accident?** ☐ Yes ☐ No

Current Medical Diagnosis _____

What are your immediate needs? _____

_____

How would you describe your health goals for the next year? _____

_____

CONSENT FOR TREATMENT AND CARE

I, the undersigned, do hereby request and consent to the performance of **Acupuncture** and **Oriental Medicine procedures.**

The methods of treatment may include, but are not limited to, **acupuncture, electrical stimulation, low-level laser therapy, massage, Chinese** or **Western herbal medicine,** and **nutritional counseling**. I've been informed that acupuncture is a **safe** method of treatment, but in a very rare instance, there may be some bruising or tingling near the needling sites that may last a few days. The herbs and nutritional supplements used are considered safe according to the standards of Western and Oriental Medicine.

I wish to rely on Sara's **professional judgment** during the course of treatment, knowing that she will always work in my best interests.

By signing below, I agree to the above named procedures. I intend this consent to cover the **entire course of treatment** for my personal condition(s). The statements I made on this form are correct and complete to the best of my knowledge.

Patient's Signature_____ **Date** _____