



Carolyn Fitzgibbons, LAc, LMT, LLC  
Acupuncture, Bodywork, Chinese Herbs

\*\*Please bring with you to your first appointment  
or email to: [acubodyherbs@gmail.com](mailto:acubodyherbs@gmail.com)

### New Patient Information

Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_ DOB: \_\_\_\_\_

Legal Gender:  Male  Female Preferred Pronouns: \_\_\_\_\_

Street Address, City, State, Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Please indicate how you would like to be contacted:

Home Phone  Mobile  Text  Email

What is best time of day to contact you?

Morning (8 am – 12 pm)  Afternoon (12 – 4 pm)  Early Evening (4 – 7 pm)  Late Evening (7 – 9 pm)

Your Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Living Situation: \_\_\_\_\_

### Emergency Contact

Emergency Contact Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

## ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

PATIENT NAME:

ACUPUNCTURIST NAME: Carolyn Fitzgibbons, LAc, LMT

(Date)

PATIENT SIGNATURE: **X**

(Or Patient Representative)

(Indicate relationship if signing for patient)

**ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE**

PATIENT NAME:

## ARBITRATION AGREEMENT

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

**Article 2: All Claims Must be Arbitrated:** It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the healthcare provider, including those working at the healthcare provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) and provide National Arbitration and Mediation ("NAM") with the party arbitrator's contact information within thirty days of the date Respondent files its initial responsive pleading. A third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties from a list of arbitrators supplied by National Arbitration and Mediation ("NAM") within thirty days thereafter. The list supplied by NAM shall be a list of between 5 and 10 arbitrators, depending upon availability. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that, where not in conflict with this agreement, the Healthcare Malpractice Dispute Resolution Rules and Procedures of NAM shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of NAM rules are available on its website at <https://www.namadr.com> or by calling 1-800-358-2550 to request a copy of the rules.

**Article 4: General Provision:** All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the healthcare provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

**Article 6: Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. \_\_\_\_\_. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name (print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian (print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Name: Carolyn Fitzgibbons, LAc, LMT, LLC Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE**



Carolyn Fitzgibbons, LAc, LMT, LLC  
Acupuncture, Bodywork, Chinese Herbs

### **Medical Intake Form**

List the names & phone numbers of any doctors or practitioners you would like me to consult with:

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What is the primary concern you would like to address in treatment?

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Other issues or concerns you would like to address?

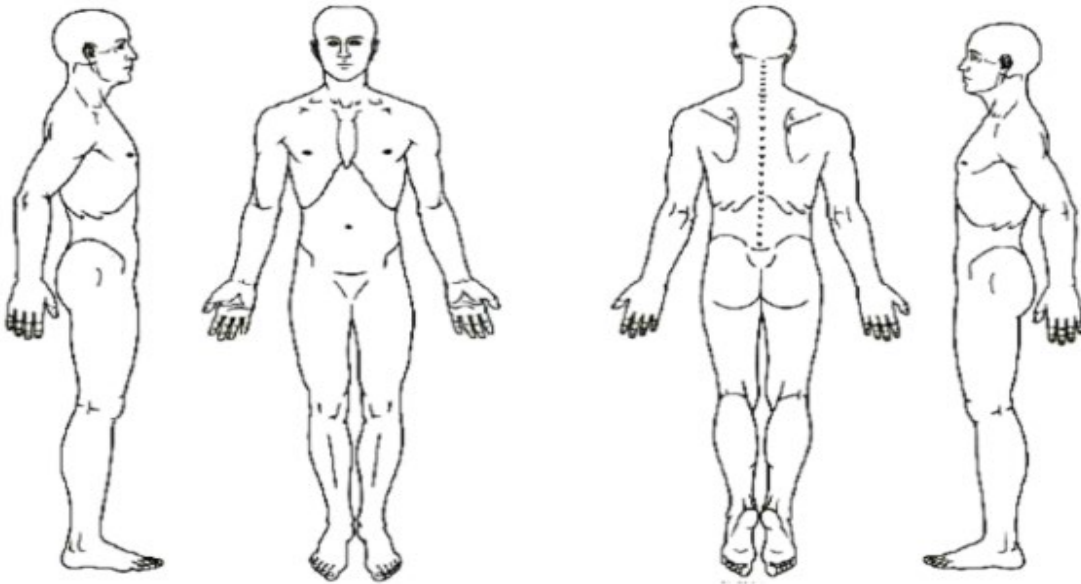
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### **Musculoskeletal:**

Using an X, please indicate any areas of current pain or weakness of the diagram below:



How would you describe your pain?  Sharp  Dull  Ache  Throbbing

How would you rate your pain on a scale of 1 – 10 (10 being as bad as it could be, nothing else matters):

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Does this pain move to another part of the body/other side of the body?  Yes  No

If yes, please explain: \_\_\_\_\_

Please list any past accidents, injuries or surgeries, including dates: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you experience numbness and/or tingling in any part of your body?  Yes  No

If yes, please explain: \_\_\_\_\_

**Health Habits:**

Do you exercise?  Yes  No

If yes, what type of exercise and how frequent: \_\_\_\_\_

\_\_\_\_\_

**Sleep:**

What time do you go to sleep? \_\_\_\_\_

What time do you wake? \_\_\_\_\_

Do you feel rested when you wake?  Yes  No

Difficulty:  Falling asleep  Staying asleep  Toss & turn  Waking early, unable to get back to sleep

Dreams:  Vivid dreams  Nightmares  I don't dream

Other sleep issues: \_\_\_\_\_

**Temperature:**

Do you tend to feel hot or cold and/or experience hot flashes or cold chills?  Yes  No

If yes, please explain: \_\_\_\_\_

Do your feet and/or hands tend towards cold?  Yes  No

If yes, please explain: \_\_\_\_\_

**Stress, Anxiety, Depression:**

What is your level of stress and/or anxiety on a scale of 1 -10 (10 being the most stressed/anxious): \_\_\_\_\_

What does your stress/anxiety feel like? \_\_\_\_\_

What triggers your stress/anxiety? \_\_\_\_\_

Do you have panic attacks?  Yes  No

If yes, please describe: \_\_\_\_\_

What helps you conquer stress/anxiety? \_\_\_\_\_

What is your level of depression on a scale of 1 – 10 (10 being the most depressed): \_\_\_\_\_

Does depression interfere with the ability to live your life how you'd like to live it?  Yes  No

If yes, how often: \_\_\_\_\_

**Energy level:**

(Use a scale of 1-10, 10 being having enough energy to get through your day easily with some left over)

Overall: \_\_\_\_\_

Upon waking: \_\_\_\_\_

Time of day of peak energy: \_\_\_\_\_

Time of day of low energy: \_\_\_\_\_

Do you need caffeine to get through the day?  Yes  No

**Headaches:**

Do you get headaches?  Yes  No

If yes, how often?  Occasionally  Weekly  Daily

Where does it occur in or on your head, and what does it feel like? \_\_\_\_\_

\_\_\_\_\_

Do you experience dizzy spells?  Yes  No

If yes, how often?  Occasionally  Weekly  Daily

**Memory:**

Do you have any issues with your memory?  Yes  No

If yes, please explain: \_\_\_\_\_

“Foggy” brain or “fuzzy” thinking?  Yes  No

If yes, please explain: \_\_\_\_\_

**Eyes:** Issues with  Vision  Floaters  Dryness  Redness  Itchy Other: \_\_\_\_\_

**Nose:**  Congestion  Runny  Decreased Sense of Smell Other: \_\_\_\_\_

**Allergies:**

Do you have allergies to foods, products, and/or environment:  Yes  No

If yes, please explain: \_\_\_\_\_

Is it seasonal:  Yes  No

**Ears:**  Ringing  Loss of Hearing  Sound Sensitivity  Rushing Noise Other: \_\_\_\_\_

**Teeth/Jaw:**  TMJ  Teeth Grinding  Jaw Pain Other: \_\_\_\_\_

**Chest & Breathing:**

Tightness  Pain  Palpitations  Asthma  Shortness of Breath Other: \_\_\_\_\_

How often?  Occasionally  Weekly  Daily Other: \_\_\_\_\_

Cough:  Morning  Daytime  Nighttime  All the time

Is it:  Dry  Phlegm Producing  Difficult to Expectorate Phlegm

What color, if any, is the phlegm?  Clear  White  Yellow  Brown  Green

Do you use tobacco or nicotine products (currently or in the past)?  Yes  No

If yes, for how long and how often per day / week? \_\_\_\_\_

**Appetite:**

Do you get hungry during the day?  Yes  No

Do you feel like you eat too much or too little?  Too much  Too little  No

Do you feel energized after eating or feel like you need a nap?  Energized  Nap

Do you crave anything: \_\_\_\_\_

**Diet:** What does your food intake on a typical day look like? Please include times of meals.

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What kind of diet do you have?  Mixed food diet (animal & plant)  Vegan  Vegetarian  Lactose Intolerant  
 Gluten Intolerant  Egg/Albumen Allergy  Corn/Soy Intolerance  
 Special Diet: \_\_\_\_\_

What is your primary eating habit?  Skip Meals  No Breakfast  One Meal/Day  Two Meals/Day  
 Three Meals/Day  Eat for Comfort  Snacking Through the Day

**Fluid Intake:**

Do you get thirsty?  Yes  No

How much water do you drink in a day? \_\_\_\_\_

Do you add anything to your water?  Yes  No

If yes, what do you add? \_\_\_\_\_

Do you drink coffee or tea?  Coffee  Tea  Neither

What type do you prefer? \_\_\_\_\_

Cups/Day? \_\_\_\_\_

Do you drink carbonated drinks?  Yes  No

If yes, what kind(s) and how many cans/day: \_\_\_\_\_

What other kinds of beverages (including alcohol) do you drink and how often? \_\_\_\_\_

Do you utilize sugar substitutes?  Yes  No

If yes, what kind?  Agave  Honey  Maple Syrup  Truvia  Monk Fruit

Aspartame (NutraSweet, Equal)  Saccharin (Sweet N Low, Sugar Twin)

Acesulfame (Sunnett, Sweet One)  Sucralose (Splenda)

What temperature do you prefer your drinks to be?  Cold  Room Temp  Warm  Hot

**Digestion:**

Do you experience:  Bloating  Pain after Eating  Bowel Movement after Eating  Frequent gas  
 Heartburn  Reflux

Other: \_\_\_\_\_

**Abdominal Pain:**

Location of pain (if any):  Middle Abdomen  Lower Abdomen  Both

Related to food intake?  Yes  No  Sometimes



What does the pain feel like?  Dull  Sharp  Like a Spasm

What makes it feel better?  Pressure  Heat  Cold Other: \_\_\_\_\_

**Bowels:**

How many times a day/week do you have a BM? \_\_\_\_\_

Any difficulty in going?  Yes  No If yes, please describe: \_\_\_\_\_

Any pain?  Yes  No If yes:  Before  During  After

Any blood or mucus in your stool?  Yes  No

Stool description(s):  Well-formed  Soft  Tend toward diarrhea  Tend toward constipation

Is the stool ever extra smelly?  Yes  No Any current or past hemorrhoids?  Yes  No

**Urination:**

Do you feel your output is about equal to your intake?  Yes  No

Any dribbling?  Yes  No Any incontinence?  Yes  No

Any blood in your urine?  Yes  No Does it ever burn?  Yes  No

Color of urine?  Clear  Light Yellow  Yellow  Dark Yellow

**Menstruation:**

Age of onset: \_\_\_\_\_ Age of menopause: \_\_\_\_\_

Number of days in cycle: \_\_\_\_\_ Duration of period: \_\_\_\_\_

Color of menses: \_\_\_\_\_

Any clots?  Yes  No If yes, what size?  Pea  Dime  Quarter Other: \_\_\_\_\_

Pain (before or during period):  Yes  No  Sometimes Pain level 1 – 10 (10 being worst): \_\_\_\_\_

What makes it feel better?  Pressure  Heat  Cold Other: \_\_\_\_\_

Breast tenderness:  Yes  No  Sometimes

Mood changes:  Yes  No  Sometimes

Hot flashes:  Yes  No  Sometimes

Any other PMS symptoms: \_\_\_\_\_

\_\_\_\_\_

**Pregnancy History:**

Are you currently pregnant?  Yes  No If yes, how many weeks? \_\_\_\_\_

Due Date: \_\_\_\_\_

Number of previous pregnancies: \_\_\_\_\_ Number of live births: \_\_\_\_\_

Health during pregnancy: \_\_\_\_\_

Complications during labor and delivery: \_\_\_\_\_

Health postpartum: \_\_\_\_\_

Are you currently breastfeeding?  Yes  No

**Prostate:**

Have you had a prostate exam?  Yes  No

If yes, when? \_\_\_\_\_

Any concerns?  Yes  No

If yes, please explain: \_\_\_\_\_

**Please briefly describe your vision of yourself in perfect health:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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*I \_\_\_\_\_ (print name\*) hereby certify that the information above is complete and to the best of my knowledge. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.*

Signature of Patient: \_\_\_\_\_ Date \_\_\_\_\_

\* Signature of Parent or Guardian: \_\_\_\_\_ Date \_\_\_\_\_

\* Name of Minor: \_\_\_\_\_

*\*Consent to Treatment of Minor: By my signature above, I hereby authorize the practitioner to administer eastern medical techniques to my child or dependent as she deems necessary.*

Signature of Practitioner: \_\_\_\_\_ Date: \_\_\_\_\_



Carolyn Fitzgibbons, LAc, LMT, LLC  
Acupuncture, Bodywork, Chinese Herbs

### List of Medications & Supplements

Client Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Please list ALL prescription and non-prescription drugs (i.e. over the counter, vitamins, supplements, herbs, etc.) currently being taken. Include any taken occasionally, such as aspirin for headaches, as well as those taken daily.

Medication/ Supplement Name (brand and/or generic name)	Dose	How often do you take this?	Reason for Taking	Started When?	Who prescribed it?

(Use back of page if needed.)

