Jera Wellness Acupuncture
210 W. Main St. Suite 101. Tustin. CA 92780
Phone. 714. 788. 1126 Fax. 714. 656. 0509 e-mail: Jerawellness@yahoo.com

PATIENT INFORMATION

Name:	□Male □Female □Other
DOB :	Drive Lic. #
Marital Status : S M D	Spouse Name:
Home Address :	
Phone : □Home □Cell	E-mail:
Occupation :	
Primary care Doctor:	Specialty:
Emerge. Contact & Relationship	Phone :
Insurance Company :	Policy No:
Cancellation Policy I acknowledge that I will give at least 24 hour notice of cancellation to avoid a charge for the session. This is a courtesy to other patients who may need that appointment time. I will call if I anticipate being more than 10 minutes late for my appointment. **Initials** _____	

MAJOR COMPLAINT

_____ Severe Moderate Slight

PAST MEDICAL HISTORY [Select all that apply]

AIDS	Cirrhosis	Heart Disease	Other Heart Condition
Anxiety Attacks	Connective Tissue	Heart Murmur	Other Kidney Problems
Asthma	Disorders	Hepatitis	Other Lung Problems
Autoimmune Disease	Diabetes	High Blood pressure	Panic Attack
Birth Defects	Epilepsy	Intestinal Bleeding	Paralysis
Bladder Infections	Erythematosis	Kidney Infection	Rheumatoid Arthritis
Blood Disorders	Gallstones	Kidney Stones	Seizures
Breast Tumor or Cancer	Gastric/Duodenal Ulcers	Lupus	Thyroid Problems
Bronchitis	German Measles (Rubella)	Neurologic Disorders	Tuberculosis
Cancer	Heart Attack	Other Forms of Arthritis	Varicose Veins

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MEDICAL CONDITIONS Conditions & surgeries & auto accidents you have or have had and year diagnosed.		**ALLERGIES** Medication, Seasonal, Food, Environmental	**OCCUPATIONAL CONCERNS** [Select all that apply]
Year	Condition / Surgery		Stress
			Heavy Typing/ Computer Use
			Hazardous Substances
			Heavy Lifting
			Other _____

MEDICATIONS

Prescription Name	Purpose	How long	Dose / How often	Last Dose

LIFE STYLES

Tobacco use: ☐ Yes ☐ No Alcohol use: ☐ Yes ☐ No Exercise: ☐ Regular ☐ Occasional ☐ None

FEMALES only

Currently pregnant □Yes □No	Menstrual Cycle:
Last Period:	PMS (Premenstrual Syndrome):
No. Pregnancies:	Last PAP Test:
No. Miscarriages:	Age Stopped:
Form of Birth Control:	Menopause Symptoms:

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Acupuncture Informed Consent Form

I, the undersigned, hereby request and consent to receive **acupuncture** and related procedures as deemed necessary, including **moxibustion, cupping, electro-acupuncture, and other clinically appropriate techniques**, performed by the above-named doctor or another duly authorized practitioner in this clinic.

I understand that acupuncture carries some **potential risks and complications**, which may include, but are not limited to:

- Minor bleeding or bruising at needle sites
- Nausea or fainting
- Shock or convulsions
- Temporary pain, soreness, or stiffness
- Infection
- Rare risk of perforation of internal organs

I acknowledge that only **pre-sterilized, single-use needles** will be used, which will be properly disposed of after each treatment session. I understand that **treatment results are not guaranteed**, and I rely on the provider's professional judgment to determine the safest course of treatment during each visit. **After treatment, any issues or concerns related to the treatment should be reported to and discussed with the provider first.**

Female Patients Only
I understand that acupuncture treatment during pregnancy may pose risks, including possible fetal distress.
I hereby declare that I am **not pregnant**, and there is no possibility that I may be pregnant.

Please initial here to confirm understanding and acceptance: _____

Insurance & Financial Responsibility
I understand that while this clinic accepts certain insurance plans covering acupuncture, I am responsible for any **deductibles, co-payments, or non-covered services**. I authorize the release of any necessary medical information to process insurance claims and consent to the use of my signature on such claims. I acknowledge that I am financially responsible for all charges for services rendered, regardless of insurance coverage.

By signing below, I confirm that I have read and fully understand this consent form, had the opportunity to ask questions, and voluntarily agree to the described acupuncture treatments.

Patient/Legal Guardian Signature: _____

Printed Name: _____ **Date:** _____ / _____ / _____

Provider Signature: _____ **Date:** _____ / _____ / _____