Acupuncture & Oriental Medical Professional
Integrative Acupuncture Physical Medicine Program
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Information and Terms for Demonstration Patients

Last Name:_____ **First Name:** _____ **Age:** _____
Phone #: _____ **Referring acupuncturist :** _____
Emergency contact: _____ **Phone:** _____

What is your chief complaint, condition or symptom? When and how did it begin?

_____

Please indicate by checking boxes below if any of the following apply to your medical status

- ❑ Emphysema, COPD, or other lung disease
- ❑ Smoking
- ❑ Cancer
- ❑ Implants or prosthetics. Where? _____
- ❑ Pacemaker, de-fibrillator, or spinal cord stimulator
- ❑ Irregular heartbeat/arrhythmia
- ❑ Epilepsy
- ❑ Fracture. Where? _____
- ❑ Blood clot
- ❑ Osteporosis/osteopenia
- ❑ Pregnancy
- ❑ Bleeding disorder, blood thinning medications
- ❑ Sensory loss. Where? _____
- ❑ Diabetes
- ❑ Fainting spells, anemia, low blood pressure, hypoglycemia
- ❑ Compromised immunity, immunosuppressive medications

Please check below to indicate your understanding of and agreement with the following terms of admission:

- ❑ I have received AOM Professional's *Notice of Privacy Practices* regarding my health information. I authorize release of any information necessary to coordinate emergency medical care, including disclosure to other healthcare professionals for the purpose of evaluating my health, diagnosing medical conditions, and providing treatment.
- ❑ I understand and agree that my participation as a demonstration patient in classes sponsored by AOM Professional is for the sole purpose of training and education of enrolled students, and that diagnosis and treatment provided and recommendations offered in the context of AOM Professional classes are not substitutes for or alternatives to my current medical care. I agree to address follow-up questions and requests for treatment regarding my condition(s) to my existing medical care team.

Signed: _____ Date: _____
(Name)