WELCOME

LYNNE CARYL, LAC
California State License # CF2993

Personal Information Form

(Please Print Clearly)

Initial Consultation Date _____

Updated As Of _____

Ms./Mr. | First Name | MI | Last Name

Address 1 _____

Address 2 _____

City ST Zip _____

Phone Home _____ Phone Cell _____

Phone Work _____ Phone FAX _____

Personal Email _____

Work Email _____

Occupation _____

Employer _____

Address _____

City ST Zip _____

Date of Birth _____ Social Security # _____

Refered by _____

Medical Coverage Information Carrier _____

Policy _____ Group _____

Address _____

City ST Zip _____

Contact _____ Phone _____

I hereby authorize practitioner, Lynne Caryl, L.Ac. to administer Acupuncture and related health care services to me. I understand that I am responsible for full payment at the time services are rendered to me. If my insurance carrier is being billed, I authorize Lynne Cary, L.Ac., to release any information required to process this claim. I assign and release payment for services billed to be paid directly to Lynne Caryl, L.Ac., and I understand that I am fully responsible for what my insurance does not pay.

CANCELLATION POLICY: I recognize that cancelations require a minimum of a 24 hour notice or I will be billed appropriately. If appointment time change is necessary I will give maximum notice possible.

Patient Signature _____ Dated _____

Patient ID:

Patient Type ☐ Acupuncture ☐ Jade ☐ Massage ☐ Other... _____

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Patient Name _____, _____

LC Patient ID

Patient Medical History

Main Concern _____

How Long have you had this? _____

Any Other Concern(s) _____

Present Medication(s) _____

Vitamin Supplement(s) _____

Hospitalizations/Surgeries orTreatments at this time _____

Allergies _____ Do You ☐ Smoke ☐ Drink ☐ Have Addictions

Have you ever had any of the following

☐ AIDS	☐ Diabetes	☐ Mononucleosis
☐ ARC	☐ Hepatitis	☐ Bladder or Kidney Infections
☐ Polio	☐ Shingles	☐ Gall Bladder Problems
☐ Rheumatic Fever	☐ Epstein/Barr	☐ Yeast Infections
☐ Cancer	☐ Heart Disease	☐ Severe Trauma/Accidents
☐ Herpes	☐ Psoriasis	☐ Other...

Have you trouble with:

☐ Appetite	☐ Headaches	☐ Weight Gain or Loss	☐ Difficulty
☐ Bowels	☐ Digestion	☐ Taste in mouth or bad breath	☐ Other...
☐ Ears	☐ Breathing	☐ Teeth/Gums/Mouth sores	
☐ Eyes	☐ Catching Colds	☐ Energy Fluctuations	
☐ Nose	☐ Palpitations	☐ Night Sweats	
☐ Joints	☐ Sexual Energy	☐ Other unusual perspiration	
☐ Skin	☐ Dizziness	☐ Convulsions/Twitching	
☐ Sleep	☐ Hemorrhoids	☐ Spasms/Cramps	
☐ Moods	☐ Stress/Tension	☐ Nerve pain/Sciatica	
☐ Thirst	☐ Food Cravings	☐ Chest pain or Palpitations	
☐ Dreams	☐ Sore Throat	☐ Relationship difficulties	
☐ Coughs	☐ Urination(up at night?)	☐ Being too hot or cold	

Women Only

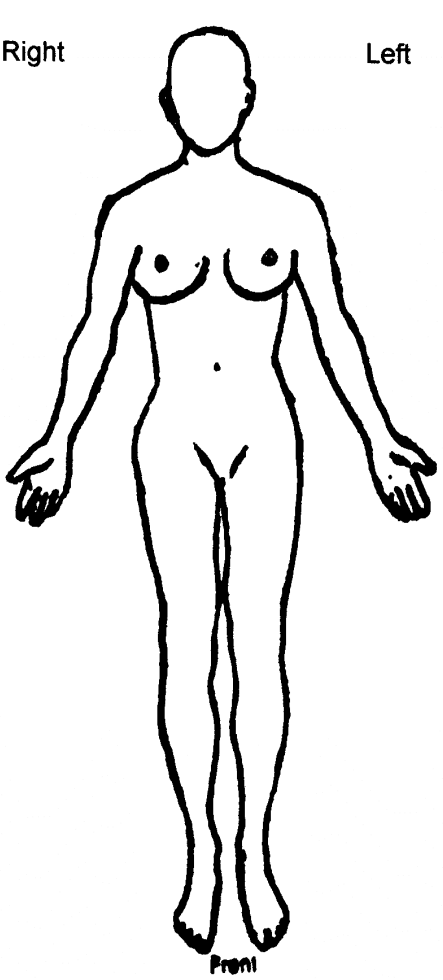
Menses? ☐ Yes ☐ No Describe your flow: ☐ Heavy ☐ Light ☐ Regular ☐ Other...

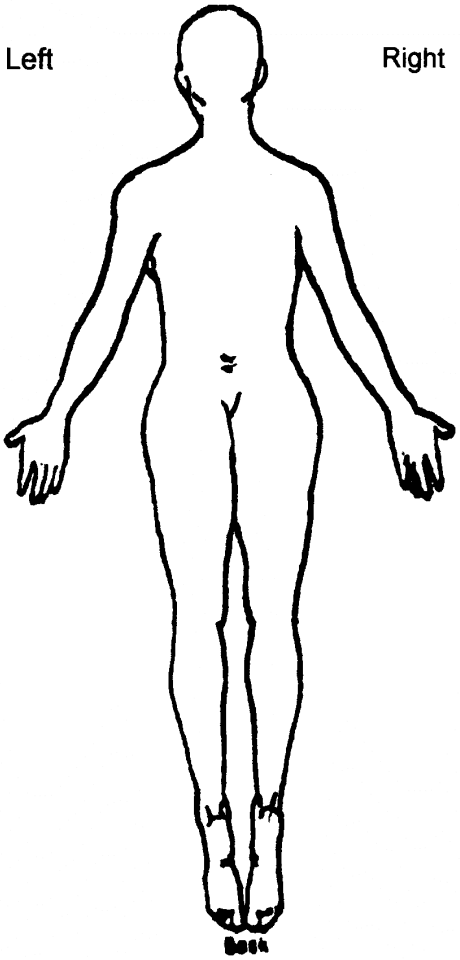
Do you have Pain? ☐ Yes ☐ No If yes: ☐ Before ☐ During ☐ After ☐ PMS

Pregnancies: Children _____ Abortion _____ Miscarriages _____

Name _____ Date __/__/____

Mark area(s) of concern, and describe history of sensations:





HARBOR ACUPUNCTURE
AND FACIAL REJUVENATION CENTER

1240 7th Ave.
Santa Cruz, CA 95062
831 476-1992

I hereby voluntarily consent to treatment of Oriental Medicine by Harbor Acupuncture (Licensed Acupuncturist, State of California License # CF2993). The procedures used in this treatment include any or all of the following: acupuncture (with or without electrical stimulation), cupping, moxabustion, muscle stimulation, and prescription of herbs or nutritional supplements. The nature, consequences, and potential benefits and risks of these procedures have been fully explained to me.

I am aware that Acupuncture may result in certain side effects, including discomfort at the site of needle insertion, local bruising, slight bleeding, weakness, fainting, nausea, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to treatment. No guarantees have been made as to the responsiveness of my condition to treatment.

We only use sterile disposable needles.

I hereby release the practitioner from any and all liability except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue treatment anytime.

Print Name:_____

Signature: _____ Date:_____