SMOKING HISTORY FORM

CONFIDENTAL HEALTH INFORMATION AND HISTORY:

NAME: _____ **BIRTHDATE:** _____

ADDRESS: _____ **CITY:** _____

STATE: _____ **ZIPCODE:** _____

CELL PHONE: _____ **CELL CARRIER:** _____

EMAIL: _____ **(not used for solicitation)**

BIRTHDATE: _____ **REFERRED BY:** _____

IN EMERGENCY, NOTIFY: _____

How long have you been smoking? _____

Indicate what you smoke: _____Cigarettes _____Cigars _____Chewing Tobacco

At this present time, how much are you smoking?
____ less than 1 pack per day? ____ 1-2 pk. a day? ____ 3 or more pk. a day?

Have you ever quit smoking before? _____ Yes _____ No If so, for how long? _____

Have you quit more than once? _____Yes ____ No

What methods have you used? _____Nicotine gum/patch _____ Cold Turkey _____Hypnosis
_____ Wellbutrin/Zyban _____ Acupuncture _____ Other

What is your motivation to quit smoking at this time? _____
_____

Have you ever experienced Acupuncture before? _____ Yes ____ No

Do you understand that our program to quit smoking involves two treatments to be successful?
_____Yes _____No

Do you understand that smoking at any time after the first treatment will interfere with your treatment results? _____Yes _____ No

Do you have a pace maker or any other type of electrical implant? _____ Yes ____ No
Women Only: Are you pregnant? _____Yes ____No

YOUR ACUPUNCTURE TREATMENT SESSION FOR SMOKING CESSATION

CONGRATULATIONS for making the decision to lead a healthier lifestyle! Acupuncture will help you to overcome the physical addiction to nicotine and to significantly reduce or eliminate the cravings and stress that are associated with the withdrawal process.

The two-treatment program is given on two consecutive days, (initial studies on this program show an 80-85% success rate). The first acupuncture treatment will reduce the withdrawal symptoms to a tolerable or insignificant level. After the second treatment, there is usually minimal craving or other symptoms of withdrawal.

It is very important that you do not smoke during this time or you will need to start over with two treatments again.

A small percentage of people need a third treatment because their bodies break down the nicotine more slowly. Another group of people, those with very high stress levels, may also need an extra treatment. These treatments further lower your stress level, thus reducing the desire to use nicotine as a way to cope with stress. If you feel you are in the VERY HIGH STRESS LEVEL GROUP, please let your acupuncturist know.

Typically, it is recommended that you reduce caffeine consumption at this time, as excess caffeine creates stress hormones and you want to remain as calm as possible. Instead, try to drink more water as it helps flush the nicotine out of your body.

To reduce stress, it is very beneficial to exercise. If you don't have a regular program, take a walk in the fresh air or walk in place for several minutes near an open window.

Now is the time to exercise your willpower. If you feel the urge to smoke, start thinking about all the reasons why you want to quit. It is good to repeat a positive affirmation such as "every day I am becoming healthier and healthier," or "I am strong and healthy," or make up your own saying that will fit your desired goal to quit.

Some people who have successfully quit smoking have found it supportive to come in for an extra treatment when they are experiencing a stressful period in their lives. The treatment reduced their stress and they were able to overcome the psychological desire to smoke again. This individual treatment is called a booster. A smoking booster is available as one treatment if you have not had any nicotine. If however, you've smoked, the entire two-step smoking treatment must be completed again.

For more information about your upcoming treatment, make sure you read the brochures "Quit Smoking", and "When Smoker's Quit" both available on our website at: **www.mtacupuncture.com**

Payment in full is required at the time of the appointment. No personal checks accepted.

PATIENT INFORMED CONTENT/VOLUNTARY TREATMENT/MUTUAL ARBITRATION AGREEMENT

I, _____, hereby voluntarily consent to receive Acupuncture Therapy. I understand that Acupuncture is performed by the insertion of special, fine, sterile, disposable needles (with or without electrical stimulation) through the skin, to certain points on the body in an attempt to balance energy and thus improve body function and maintain good health. The techniques used will include, but are not limited to, one or more of the following: Acupuncture, Electro-Acupuncture, Cupping, Herbs and Guasha.

I acknowledge that I have read and understand the cover sheet entitled "Your Acupuncture Treatment Session" which defines the above procedures.

I acknowledge that although rare, certain side effects may result from Acupuncture. These can include bruising, mild pain, or aggravation of symptoms. These effects are unusual and of short duration. Other possible side effects are: burns, pneumothorax, and spontaneous miscarriage.

I understand that the evaluation given me and energetic assessment of the Acupuncture channel network, and in no way purports to be, or replaces the occidental or western medical examination and diagnosis. In the course of the evaluation, there may be reference to the state of various "organs" such as the heart, liver, spleen, etc., which actually refer to energetic channels of the same name.

I acknowledge that the Acupuncture Therapists is not and does not profess to be a medical doctor and does not advise on the use of medically prescribed pharmaceuticals or medical treatment, nor does the therapist give any substances by injection. I do not apply for or wish to receive a medical diagnosis and/or medical or surgical treatment.

I acknowledge that the Acupuncture Therapist has received training from an accredited Acupuncture school and has been certified by the school and by the National Commission for Certification of Acupuncturists. (NCCAOM).

It is agreed by all parties that any dispute, claim, allegation or lawsuit related to the treatment, care, or professional services rendered under this agreement will be determined and adjudicated by submission to arbitration as provided by the American Arbitration Association, in accordance with Michigan law. All parties to this contract, by entering into it, agree that they are freely and voluntarily consenting to waiving the right to have any such dispute decided in a court of law before a jury.

PAYMENT IN FULL IS REQUIRED AT THE TIME OF APPOINTMENT.
We accept payment by cash, checks, MasterCard, Visa or Discover. We will NOT bill your insurance company for this service, however, we will provide you with a receipt that you can send to your insurance company for possible reimbursement. Acupuncture may or may not be covered by (your) insurance company. It is your responsibility to check with your insurance company regarding coverage.

I agree to accept all responsibility for payment of services rendered.

Signature of patient (or legal guardian) _____

Date _____ Witnessed by _____