Welcome!

We specialize in acupuncture and other complementary healing methods. Our interest is in providing balanced optimal care, elimination of root causes of symptoms of distress when possible, and maintenance of wellbeing. To better serve you, please provide us with the following information.

Full Name _____ Date_____

Address_____City_____Zip_____

Phone/ primary_____ secondary _____ email_____

Occupation/ Employer_____ Birth Date _____

Please tell us who referred you _____

Current or previous doctor's name, specialty_____

Existing conditions or concerns you would like us to address _____

Other conditions or concerns you would like to address secondary to these _____

_____

What type of service do you desire?

_____1) Relief of symptoms/pain control
_____2) Eradication of tendencies causing your condition
_____3) Maintenance care--regular balancing or "tune ups" to keep in good health and wellbeing

How would you classify your condition if present?

_____1) Minor
_____2) Involved
_____3) Fairly severe and progressively getting worse
_____4) Serious

This is not a detailed history. Please circle all of the below conditions you experience if you are seeking acupuncture as part of your treatment:

Tendency to faint, bruise or discolor easily, bleed for a long time, have hepatitis, have HIV, have high blood pressure, any heart problems, any respiratory problems, been treated by acupuncture before, are taking any other therapies at the same time, had surgery before, taking any medications, are hungry at the present time, are exhausted at the present time.

Consent for Acupuncture Care: I, the undersigned, request and consent to acpuncture and other traditional Oriental Medical treatments and modern applications of Oriental Medicine by Sydney Walker, L.Ac., and other acupuncturists who may serve as alternates, whether or not they are signatories to this form.

I understand that there is no implied or stated guarantee of results. I realize that there are some risks to treatment, including but not limited to , bruising and/or slight bleeding, burns, and fainting. The risk of infection is very small because only pre-sterilized, disposable needles are used.

I understand and agree to the above:

Patient's Name: _____Date:_____

Responsible Party: _____ Relationship:_____

Sydney Annette Walker, L.Ac.
Informed Consent for Treatment

An acupuncturist may offer acupuncture, electroacupuncture, perform or prescribe use of Oriental massage, acupressure, moxabustion, cupping, breathing techniques, exercise, heat, cold, magnets, nutrition, diet, herbs, plant, animal and mineral products, and dietary supplements to promote, maintain, and restore health. The risks involved in acupuncture include fainting, bruising, and slight bleeding. A punctured lung could result but it is very rare and acupuncturists are trained to avoid these occurrences.

Sydney also offers Bio-energetic Healing methods which may be alternative or complementary to services licensed by the state of California. These methods include Applied Physiology, Allergy Desensitization Techniques, Reiki, Matrix Energetics, Emotional Freedom Technique, (EFT), Pulsed Electromagnetic Field Therapy, (PEMF), Micro-current and light therapy, and other forms of intuitive energy and somatic healing gathered from 30 years of work and study. I may ask for and receive more information about these modalities. Many energy-oriented therapies are considered experimental and have not been substantiated by mainstream medicine.

I understand that the services from Sydney Walker, L.Ac. are intended to support positive changes for me, but that none of the licensed or unlicensed services offered or energy work performed guarantees any kind of cure or specific outcome. I take full responsibility for my health and wellness.

I, the undersigned, am aware of both the benefits and risks of acupuncture treatment and give my consent for treatment.
I choose to include complementary healing arts in my treatments unless the statement below is checked.

(I choose to receive only treatments within the scope of the California licensed acupuncturist. __)

Client name _____

Signature _____ Date _____