**PHYSICIAN CARE FORM**

**Five Elephants Acupuncture**

Date: ­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please review the following conditions and indicate those that you have been diagnosed with and/or are currently under the care of a physician for:

|  |  |  |
| --- | --- | --- |
|  | Diagnosed | Currently under physician care |
| Hypertension (high blood pressure) |  |  |
| Cardiac condition |  |  |
| Acute, severe abdominal pain |  |  |
| Undiagnosed neurological changes |  |  |
| Unexplained weight loss or gain of more than 15% of body weight in last 3 months |  |  |
| Suspected bone fracture or dislocation |  |  |
| Suspected systemic infection |  |  |
| Serious hemorrhagic (bleeding) disorder |  |  |
| Acute respiratory distress without a previous history |  |  |
| Pregnancy |  |  |
| Cancer |  |  |
| Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

Please provide the following information about your treating physician(s):

Physician name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am aware that I should not replace treatment from a physician with acupuncture, or any other holistic modality, for the above conditions.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_