chiropractic wellness center

Acupuncture Consent Form

Please read and answer the following questions as accurately as possible.

1)	Have you ever been exposed to hepatitis?	YES	NO
2)	Have you ever had any form of hepatitis?	YES	NO
3)	Have you ever been exposed to HIV (AIDS)?	YES	NO
4)	Do you have HIV or AIDS?	YES	NO
5)	Have you ever been exposed to any other blood born disorders?	YES	NO
6)	Do you take blood thinners or anticoagulants?	YES	NO
7)	Do you take aspirin on a regular or frequent basis?	YES	NO
8)	Do you take steroids on a regular or frequent basis?	YES	NO
9)	Do you have any clotting disorders or bleed easily?	YES	NO
10)	Do you bruise easily?	YES	NO
11)	Are you currently pregnant?	YES	NO

I do hereby authorize and direct Dr. Lorie Lofquist to perform acupuncture, cupping, and/or any meridian therapy as needed.

_____ _____

Patient Name Date

_____ _____

Patient or Guardian Signature Dr. Lorie Lofquist/ Dr. Christine Barney