

PHYSICIAN CARE FORM

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

I have been diagnosed with the following condition(s): (Check all that apply)

- 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: \_\_\_\_\_

I am currently under the care of a physician for: (Check all that apply)

- 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: \_\_\_\_\_

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: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_