

**ACUHEALTH LLC
PHYSICIAN CARE FORM**

Date: _____

I have been diagnosed with the following condition(s): (Check all that apply & give name and phone number of physician.)

- 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: _____

Phone: Home: _____ Work: _____ Cell: _____