

**STANLEY J. HUBBARD**  
*Acupuncture Physician*

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**PATIENT INTAKE FORM**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Date of Birth \_\_\_\_\_

Occupation \_\_\_\_\_

1. Please state your reason for coming. \_\_\_\_\_  
\_\_\_\_\_
  2. List any health problems; include date of onset and symptoms. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  3. List any medications that you are taking. \_\_\_\_\_  
\_\_\_\_\_
  4. Please give a brief description of your diet. \_\_\_\_\_  
\_\_\_\_\_
  5. How's your appetite. \_\_\_\_\_
  6. Any digestion problems such as heartburn, ulcers, gas? \_\_\_\_\_  
\_\_\_\_\_
  7. How often do you move your bowels? \_\_\_\_\_
  8. How is your sleep? \_\_\_\_\_
  9. List any other aches, pains, or problems not listed above. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  10. Medical History: List major illnesses and surgeries. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  11. Have you ever tested positive for HIV? Yes \_\_\_\_\_ No \_\_\_\_\_  
Have you ever tested positive for Hepatitis? Yes \_\_\_\_\_ No \_\_\_\_\_
  12. Were you referred to us by anyone? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, by whom? \_\_\_\_\_
  13. List drug, alcohol, and cigarette intake. \_\_\_\_\_
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**Consent for Acupuncture Treatment**

1. The State of Georgia requires a signed consent form before a patient can receive acupuncture treatment.
2. I understand that Stanley J. Hubbard, Licensed Acupuncturist in the State of Georgia, is not an MD and therefore will not diagnose my problem. If I want a medical diagnosis then I should seek this from a licensed MD.

I, \_\_\_\_\_ (print name), give consent to receive acupuncture from Mr. Hubbard.

\_\_\_\_\_ (signature)

\_\_\_\_\_ (date)