Medical Acupuncture & Wellness

ACUPUNCTURE CLIENT INTAKE FORM

Please complete this questionnaire carefully. The information you provide will assist in creating a complete health profile for you. All of your answers are absolutely confidential. If you have any questions, please ask.

Name	E-mail Address	Today's Date
Address	City	State Zip
Date of Birth (month/date/year)	Occupation	
Preferred Phone	How you heard about us	
Emergency Contact	Phone	Relationship
Physician's Name	Phone	

MAIN COMPLAINT (symptoms, diagnosis, duration of condition, etc.)/ REASON FOR VISIT: _____
_____
_____

SURGERIES (please include date of procedure): _____
_____

SIGNIFICANT TRAUMA (auto accident, fall, psychological, abuse, etc.): _____
_____

BIRTH HISTORY (prolonged labor, forceps delivery, etc):_____
_____

MEDICATIONS (prescription, OTC):_____
_____

ALLERGIES (food, drug, chemical):_____

DIET: Meals/day_____ Snacks_____ Caffeinated drinks/day_____ Alcohol drinks/day_____ Tobacco_____

VITAMINS/ SUPPLEMENTS/HERBS: _____

EXERCISE (type, frequency, duration):_____

PATIENT NAME _____ ☐ M ☐ F DATE _____

PERSONAL HISTORY
PLEASE CHECK ANY CONDITIONS OR SYMPTOMS YOU HAVE NOW

☐ Arthritis	☐ Liver/Gallbladder Disease	☐ Stroke	☐ Heart Disease
☐ High/Low Blood Pressure	☐ Hypoglycemia/Hyperglycemia	☐ Kidney Disease	☐ Elevated Blood Cholesterol
☐ Cancer	☐ Diabetes	☐ Food Allergies/Intolerance	☐ Diverticulitis/Irritable Bowels
☐ Ulcer	☐ Seizures	☐ Hepatitis	☐ Raynaud's Disease
☐ Chronic Fatigue	☐ Anemia	☐ Thyroid Imbalance	☐ Allergies
☐ Fibromyalgia/Polymyalgia	☐ Lyme Disease	☐ Chronic Pain Condition	☐ Impotence
☐ Gastritis	☐ Asthma	☐ Infertility	☐ Emphysema

FAMILY MEDICAL HISTORY
PLEASE CHECK ANY CONDITION THAT APPLIES TO YOUR IMMEDIATE FAMILY.
PUT AN **F** (FATHER), **M** (MOTHER), **S** (SISTER), **B** (BROTHER), **GM** (GRANDMOTHER), **GF** (GRANDFATHER) NEXT TO CHOICE

☐ Diabetes	☐ Seizures	☐ Heart Disease	☐ Stroke
☐ High Blood Pressure	☐ Allergies	☐ Cancer	☐ Asthma
☐ Other			

PLEASE CHECK IF YOU HAVE HAD ANY OF THESE SYMPTOMS LISTED IN THE LAST THREE MONTHS:

GENERAL

☐ Poor Appetite	☐ Poor Sleep	☐ Fatigue	☐ Fevers
☐ Chills	☐ Night Sweats	☐ Sweat Easily	☐ Tremors
☐ Cravings	☐ Localized Weakness	☐ Poor Balance	☐ Change in Appetite
☐ Bleed/Bruise Easily	☐ Weight Loss/Gain	☐ Peculiar Taste/Smells	☐ Dental/Gum Problems
☐ Muscle Weakness/Fatigue	☐ Strong Thirst (cold/hot drinks)		

SKIN AND HAIR

☐ Rashes	☐ Ulcerations	☐ Hives/Allergic Dermatitis	☐ Itching
☐ Eczema/Psoriasis	☐ Dandruff	☐ Loss of Hair	☐ Moles
☐ Skin Discolorations	☐ Acne	☐ Change in Skin/Hair Texture	☐ Face Flushing

HEAD, EARS, NOSE, AND THROAT

☐ Dizziness	☐ Difficulty Swallowing	☐ Migraines	☐ Eye Glasses
☐ Eye Strain	☐ Eye Pain	☐ Poor vision	☐ Night Blindness
☐ Color Blindness	☐ Cataracts	☐ Blurred Vision	☐ Earaches
☐ Ringing in Ears	☐ Poor Hearing	☐ Spots in Front of Eyes	☐ Sinus Problems
☐ Nosebleeds	☐ Recurrent Sore Throats/Colds	☐ Teeth Grinding	☐ Facial Pain
☐ Headaches (where/when)	☐ Dental Problems	☐ Jaw Clicks/Locks	☐ Sores on Lips/Tongue

CARDIOVASCULAR

☐ Chest Pain	☐ Irregular Heartbeat	☐ Palpitations at Rest	☐ Fainting
☐ Cold Hands/Feed	☐ Swelling of Hands/Feet	☐ Blood Clots	☐ Phlebitis
☐ Shortness of Breath	☐ Varicose/Spider Veins	☐ Pressure in Chest	

RESPIRATORY

☐ Cough	☐ Coughing Blood	☐ Asthma	☐ Bronchitis
☐ Pneumonia	☐ Pain with Deep Inhalation	☐ Tight Sensation in Chest	☐ Wheezing
☐ Difficult to Inhale/Exhale	☐ Production of Phlegm		

Any Other Lung Condition: _____

GASTROINTESTINAL

☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Constipation
☐ Gas	☐ Belching	☐ Black Stools	☐ Blood in Stools
☐ Indigestion	☐ Bad Breath	☐ Rectal Pain	☐ Hemorrhoids
☐ Bloating/Edema	☐ Chronic Use of Laxatives	☐ Loose Stools (>2 per day)	☐ Abdominal Pain/Cramps
☐ Changes in Appetite	☐ Acid Reflux	☐ Hernia	

Any Other Problems with Your Stomach/Intestines: _____

UROGENITAL

☐ Pain on Urination	☐ Frequent Urination	☐ Blood in urine	☐ Urgent Urination
☐ Unable to Hold Urine	☐ Kidney Stones	☐ Scanty Flow	☐ Copious Flow
☐ Impotence	☐ Sores on Genitals	☐ Urinary Tract Infections	☐ Burning Urination
☐ Premature Ejaculation	☐ Decreased Libido	☐ Prostatitis	☐ Dribbling after Urination

Do You Wake to Urinate? ☐Yes ☐ No
What times? _____
What Color is Your Urine? _____
Any Other Problems with Your Genital or Urinary System? _____

GYNECOLOGICAL/REPRODUCTIVE

No. of Pregnancies _____
No. of Births _____
No. of Miscarriages _____
No. of Premature Births _____
No. of Abortions _____
Are you Pregnant? ☐Yes ☐ No
Do You Practice Birth Control? ☐Yes ☐ No
What Type? _____
How Long: _____

Age of First Menses _____
Date of Last Menses _____
Date of last PAP/Pelvic _____

☐ Painful Menses
☐ Irregular Menstruation

☐ Ovarian Cysts	☐ Breast Lumps	
☐ Vaginal Sores	☐ Fibrocystic Breast Tissue	
☐ Vaginal Discharge	☐ Fibroid Tumors	
☐ Vaginal Dryness	☐ Infertility	
☐ Difficult Intercourse	☐ Endometriosis	

MUSCULOSKELETAL

☐ Neck Pain	☐ Shoulder Pain	☐ Hand/Wrist Pain	☐ Carpal Tunnel
☐ Knee Pain	☐ Sprains/Strains	☐ Sciatica	☐ Foot/Ankle Pain
☐ Hip Pain	☐ Muscle Pain	☐ Muscle Weakness	☐ Tendonitis
☐ Bursitis	☐ Rotator Cuff	☐ Back Pain – Upper	
☐ Back Pain – Lower	☐ Back Pain – Middle		

NEUROPSYCHOLOGICAL

☐ Seizures	☐ Loss of Balance	☐ Vertigo/Dizziness	☐ Areas of Numbness
☐ Lack of Coordination	☐ Poor Memory	☐ Concussion	☐ Depression
☐ Anxiety/Panic Attacks	☐ Bad Temper/Irritable	☐ Easily Susceptible to Stress	☐ Seasonal Affective Disorder

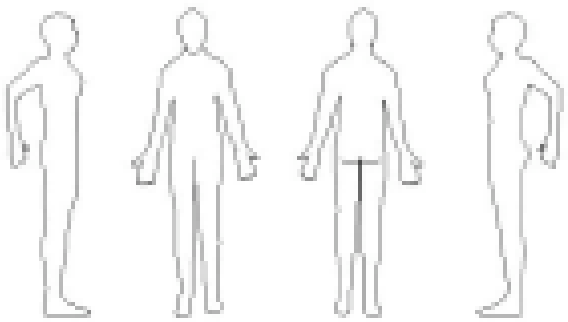
Have you ever been treated for emotional problems? ☐Yes ☐ No
Do you have a spiritual life? ☐Yes ☐ No
Have you ever considered or attempted suicide? ☐Yes ☐ No
Have you ever been treated for substance abuse? ☐Yes ☐ No

Any other neurological or psychological conditions? If yes, please explain:

_____

Indicate on the sale your satisfaction in family relationships Satisfied ---------- Distressed
Indicate on the scale your satisfaction in intimate relationships Satisfied ---------- Distressed
Indicate on the scale your satisfaction in working relationships Satisfied ---------- Distressed

PLEASE INDICATE ANY PAINFUL OR DISTRESSED AREAS



PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here._____ _. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT NAME:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE