Patient History Intake Form

Confidential

Thank you for coming for a treatment.

The questions below have been chosen carefully to help make a complete holistic evaluation. Please take the time to answer as completely as possible.

Patient Full Name: _____ Date: __ / __ / 20____

Date of Birth: __ / _ / ____ Age: ___ Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Preferred way of contacting you or leaving messages _____

Emergency Contact: _____

Primary Care Physician: _____

( ) Single ( ) Married ( ) Divorced ( ) Significant Other ( ) Widowed

Number of dependent children: _____

Main reason for seeking treatment: _____

_____

Current medical treatment and western medical diagnosis: _____

_____

Current Medications and dosages, including prescribed and over the counter: _____

_____

Current vitamins, herbs, and other supplements:

_____

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Significant illnesses (please check all that apply):

( ) Asthma	( ) Cancer	( ) Chronic Fatigue	( ) Depression
( ) Diabetes	( ) Eating Disorder	( ) Heart Disease	( ) Hepatitis
( ) HIV/AIDS	( ) Obesity	( ) Multiple Sclerosis	( ) High Blood Pressure
( ) Seizures	( ) Shingles	( ) Hypo/Hyperthyroid	( ) Stomach ulcers
( ) Stroke	( ) STD	( ) Rheumatic fever	( ) Pneumonia
( ) Other	_____		

Please check if any of the following are true:

( ) I have a pacemaker

( ) I am taking Coumadin/Warfarin

( ) I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs)

Please list any surgeries you've had, including dates: _____

_____

Please list any significant physical or emotional trauma (car accidents, sports injuries, death of family members, etc.) _____

_____

Please list any allergies or food sensitivities: _____

_____

Family Medical History (please specify family member):

	Siblings	Mother	Father	Grandparents
Asthma				
Cancer				
Depression				
Diabetes				
Eating Disorder				
Heart Disease				
High Blood Pressure				
Hypo/Hyperthyroid				
Multiple Sclerosis				
Obesity				
Stomach ulcers				
Stroke				
Other				

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Lifestyle (please check all that apply and note frequency of use):

( ) Tobacco _____
( ) Alcohol _____
( ) Recreational drugs _____
( ) Caffeinated beverages _____
( ) Tattoos _____
( ) Recent travel abroad Where _____

Please list types of exercise/physical activity and frequency: _____

_____

Please list your dietary preferences and frequency of meals and snacks:

_____

_____

Please rate how you feel about the following areas of your life

Area	Great	Good	Fair	Poor	Bad	Comments:
Work						
Health						
Love						
Family						
Money						
Spirituality						
Self						
Diet						
Exercise						

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Please check all that apply:

Head
( ) Concussion
( ) Headaches
( ) Dizziness
( ) Memory Loss
( ) Migraines
( ) Hair loss
( ) Other _____

Eyes
( ) Blurred Vision
( ) Pain
( ) Dryness
( ) Redness
( ) Glasses/Contacts
( ) Eyestrain
( ) Color blindness
( ) Night blindness
( ) Cataracts
( ) Floaters
( ) Other _____

Ears
( ) Poor hearing
( ) Ringing in the ears
( ) Frequent ear infections
( ) Other _____

Nose
( ) Frequent colds
( ) Sinus infections
( ) Allergies
( ) Nosebleeds
( ) Runny nose
( ) Other _____

Mouth
( ) Gum inflammation
( ) Canker sores
( ) TMJ syndrome
( ) Cold sores
( ) Unusual tastes
( ) Other _____

Throat
( ) Sore throat
( ) Difficulty swallowing
( ) Scratchy throat
( ) Other _____

Sleep
( ) Insomnia
( ) Night sweats
( ) Drowsiness
( ) Sleepwalking
( ) Nightmares
( ) Poor quantity
( ) Poor quality
( ) Other _____

Respiratory
( ) Asthma
( ) Bronchitis
( ) Chest Pain
( ) Cough
( ) Coughing Blood
( ) Difficulty breathing
( ) Phlegm
( ) Pneumonia
( ) Wheezing
( ) History of smoking
( ) Other _____

Heart and Thorax
( ) Palpitations
( ) Rapid heart beat
( ) High Blood Pressure
( ) Low Blood Pressure
( ) Tightness in chest
( ) Arteriosclerosis
( ) Heart attack
( ) Other _____

Circulation
( ) Bruise easily
( ) Cold hands/feet
( ) Fainting
( ) Phlebitis
( ) Varicose Veins
( ) Anemia
( ) Other _____

Skin
( ) Rashes
( ) Hives
( ) Dryness
( ) Dandruff
( ) Eczema
( ) Hair loss
( ) Acne
( ) Purpura
( ) Recent moles
( ) Excessive sweating
( ) Brittle nails
( ) Fungal infections
( ) Other _____

Musculoskeletal
( ) Spinal Pain
( ) Low back pain
( ) Joint Pain
( ) Arthritis
( ) Limited range of Motion
( ) Disc degeneration
( ) Osteoporosis
( ) Numbness
( ) Tingling
( ) Other _____

Gastrointestinal
( ) Poor Appetite
( ) Bad breath
( ) Excessive Hunger
( ) Excessive Thirst
( ) Heartburn/Belching
( ) Gas
( ) Abdominal Pain
( ) Parasites
( ) Nausea
( ) Vomiting
( ) Constipation
( ) Chronic Laxative use
( ) Loose stools/diarrhea
( ) Blood in stools
( ) Hemorrhoids
( ) Rectal Pain
( ) Stomach Pain
( ) Colitis or IBS
( ) Gallstones
( ) Other _____

Urogenital
( ) Frequent urination
( ) Difficult urination
( ) Burning urination
( ) Retention of urine
( ) Waking to urinate
( ) Dribbling of urine
( ) Bedwetting
( ) Bladder weakness
( ) Bladder prolapse
( ) Decreased libido
( ) Impotency/Infertility
( ) Kidney stones
( ) Itching of genitals
( ) Other _____

Neuropsychological
( ) Anxiety
( ) Irritability
( ) PMS
( ) Depression
( ) Easily Stressed
( ) Poor memory
( ) Worry
( ) Fear
( ) Seasonal Mood Disorder
( ) Social Anxiety
( ) Tics/Tremors
( ) Other _____

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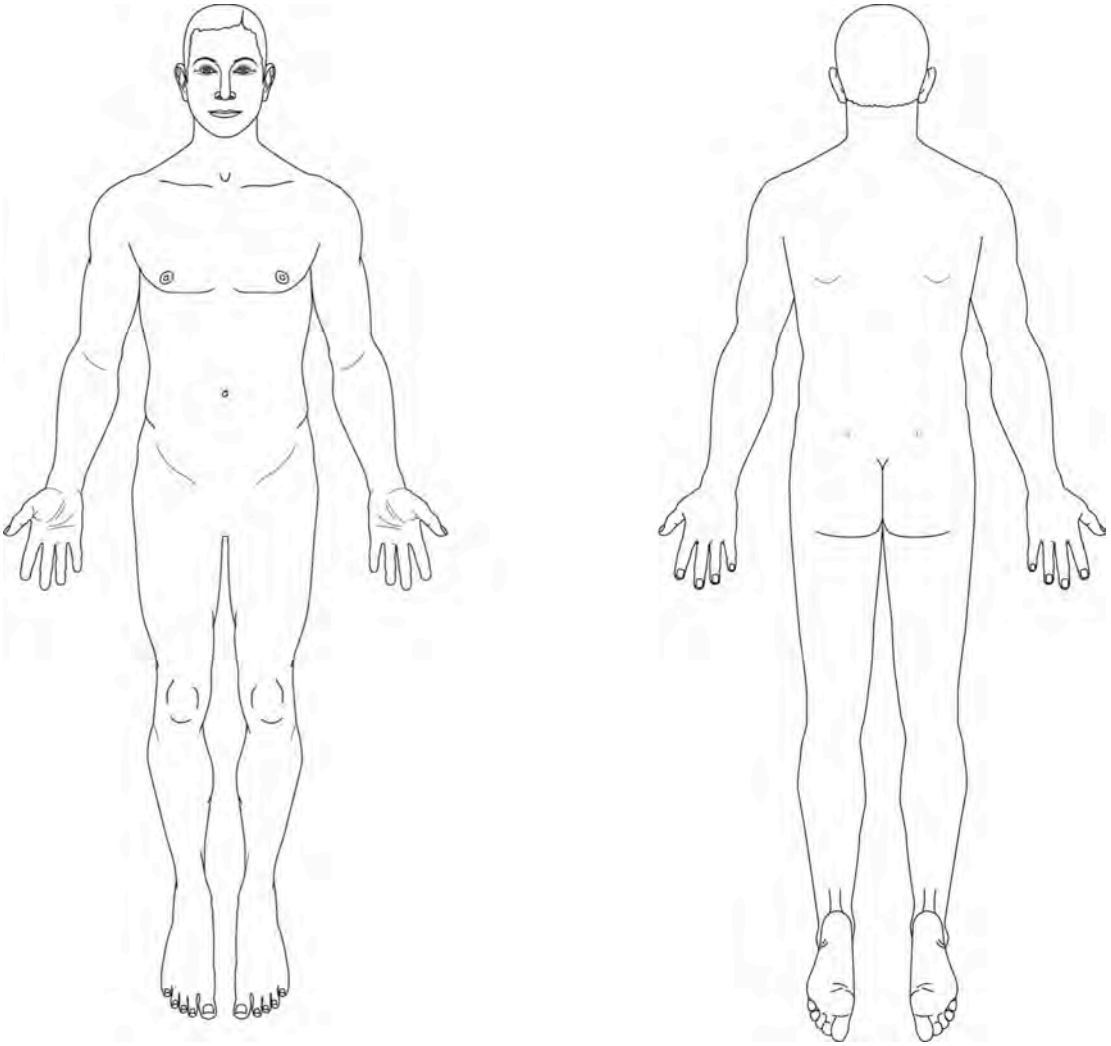
Pain Picture

Where do you have pain?



Front Back

Please mark areas of your body where you have pain today. Include all affected areas. Mark areas of radiating pain with an arrow showing the pathway of the pain. Please extend the arrow as far as the pain travels. Using the descriptive words listed below, indicate the intensity of the pain with a number 1-10, with 10 being the highest level of pain.

Aching _____	Numbness_____	Pins & Needles_____
Burning_____	Stabbing_____	Throbbing_____

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Women only

Age of first period: _____ Age of menopause (if applicable): _____

How many days do your period last? ___ How many days between periods? ___

Date of last ob/gyn exam: ___ / ___ / 20 ___

( ) Abortion	( ) Miscarriage	( ) Live birth
( ) Birth Control Pills	( ) Pain at ovulation	( ) Cramps/Low back pain
( ) Breast cancer	( ) Fibrocystic breast	( ) Ovarian cysts
( ) Fibroids	( ) Candida yeast	( ) Vaginal Discharge
( ) Vaginal odor	( ) Spotting between periods	( ) Amenorrhea
( ) Dysmenorrhea	( ) Irregular cycle	( ) HPV
( ) Other _____		

Menstrual Flow:

( ) Clots	( ) Start and stop flow	( ) Red
( ) Brownish	( ) Bright red	( ) Flooding
( ) Small amounts	( ) Other _____	

Please list any symptoms related to your period (pains, cravings, emotions, etc):

_____

Men only

Date of last prostate check-up: _____ PSA results: _____

Manual prostate exam results: _____

Lab results: _____

( ) Prostate Problems	( ) Delayed stream	( ) Dribbling
( ) Incontinence	( ) Retention of urine	( ) Rectal dysfunction
( ) Increased libido	( ) Decreased libido	( ) Premature ejaculation
( ) Impotence	( ) Back pain	( ) Groin pain
( ) Testicular pain	( ) Other _____	

Signature of Patient or Personal Representative _____

Print name of Patient or Personal Representative _____

Date ____ / ____ / 20_____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including 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 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 have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including 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 spontaneous miscarriage, 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

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 results are not guaranteed.

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.

By voluntarily signing below, I show 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 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.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE