Acupuncture

ANDERSON

Acupuncture Intake Form

Note: Information provided on this form is confidential.
It is very important the information given is complete and accurate to assist you properly in your healing process.

Please PRINT

Name: _____ Today's Date: ____ /____ /____

Date of Birth: ____ /____ /____ Age:_____ Sex: ☐ Male ☐ Female

Address: _____

_____

Telephone: (Home) _____ (Work) _____

Occupation: _____

Emergency Contact Person: _____

Relationship: _____ Telephone: _____

Primary Physician: _____ Physician's#: _____

How did you hear about us?

☐ Friend ☐ Relative ☐ Newspaper
☐ Website ☐ Westfield Street Fair ☐ Healthcare referral

Is this your first experience in Oriental Medicine and acupuncture? ☐ Yes ☐ No

How do you feel about acupuncture? _____

_____

Are you currently pregnant? ☐ Yes ☐ No

Are you presently trying to get pregnant? ☐ Yes ☐ No

What do want treated with acupuncture? _____

_____

How long have you had this condition? _____

_____

Onset: ☐ Sudden ☐ Gradual

What medical diagnosis have you received for this condition? _____

Symptoms relieved by: _____

Symptoms worsened by: _____

What other treatments have you received for this condition? _____

What medications are you taking? _____

Past Medical History

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Drug Addictions
- ☐ Allergies (food, latex)
- ☐ Asthma
- ☐ Birth Trauma
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Hepatitis A/B/C
- ☐ Herpes
- ☐ Joint Replacements
- ☐ Lyme's Disease
- ☐ Lymph Nodes removed
- ☐ Multiple Sclerosis
- ☐ Polio
- ☐ Scarlet Fever
- ☐ Seasonal Allergies
- ☐ Seizures
- ☐ Sinus Infections
- ☐ Tuberculosis
- ☐ Surgeries
- ☐ Other: _____

Family Medical History

Please list any significant family illnesses, e.g. diabetes, heart disease, respiratory conditions, blood pressure, neurological disorders, psychological disorders, arthritis

Father: _____

Mother: _____

Siblings: _____

Grandparents: _____

Exercise & Energy

How is your energy? _____

What time of day is your energy:
Highest? _____ Lowest? _____

Do you fatigue easily ? _____

What kind of exercise do you do ? _____

How often do you exercise ? _____

Emotions & Sleep

How do you feel emotionally? _____

_____

_____

Do you have: *(check all that apply)*

- ☐ Panic attacks
- ☐ Bad temper
- ☐ Depression
- ☐ Panic attacks
- ☐ Anxiety
- ☐ Poor memory
- ☐ Depression
- ☐ Difficult concentration

Are you in a relationship? ☐ Yes ☐ No

How do you feel about your relationship? _____

How do you hold stress? _____

How do you relax? _____

How do you feel about your work? _____

How long do you normally sleep? _____ hours per night

I have difficulties with: *(check all that apply)*

- ☐ Falling asleep
- ☐ Staying asleep
- ☐ Dream-disturbed sleep
- ☐ Waking up at about _____ am/pm and not being able to fall asleep again

Gastrointestinal Symptoms

- ☐ Belching
- ☐ Ulcers
- ☐ Hernia
- ☐ Nausea
- ☐ Bloating
- ☐ Indigestion
- ☐ Vomiting
- ☐ Heartburn
- ☐ Severe Stomach pain
- ☐ Vomiting of blood
- ☐ Acid regurgitation

Bowel Movements

How often? _____ time(s)/day _____ days/week

I have: *(check all that apply)*

- ☐ Constipation
- ☐ Burning sensation
- ☐ Loose Stool
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Hard stool
- ☐ Gas
- ☐ Itchiness
- ☐ Blood in stool
- ☐ Irregular bowel movements
- ☐ Undigested food in stool
- ☐ Painful bowel movements

Urinary Symptoms

Urination: How often? _____ times per day Color: ☐ Pale yellow ☐ Dark yellow/orange

I have: *(check all that apply)*

- ☐ Trouble starting stream
- ☐ Pain
- ☐ Kidney stones
- ☐ Frequent urination
- ☐ Burning
- ☐ Urinary tract infections
- ☐ Incontinence
- ☐ Blood in urine

Female GUT

At what age did you start menstruating? _____ Number of days between cycles: _____

Number of days of flow: _____ Color: _____

I have: *(check all that apply)*

- ☐ Irregular menstruation
- ☐ No flow
- ☐ Spotting between periods
- ☐ Heavy flow
- ☐ Clots
- ☐ Discomfort/ Dysmenorrhea
- ☐ Light flow
- ☐ Vaginal itching/burning
- ☐ Mid Cycle Spotting/ Pain

Vaginal discharge? ☐ No ☐ Yes Color: _____

Number of Children: _____ Male _____ Female

Miscarriages: ☐ No ☐ Yes How many? _____ Abortions: ☐ No ☐ Yes

Male GUT

I have: *(check all that apply)*

- ☐ Prostatitis
- ☐ Enlarged Prostate
- ☐ Impotence
- ☐ Libido
- ☐ Blood/mucous discharge
- ☐ EDS

Muscles, Joints & Bones

Do you have pain or tightness? ☐ No ☐ Yes Where? _____

The pain is:

- ☐ Sharp
- ☐ Numbing
- ☐ Burning
- ☐ Dull
- ☐ Superficial
- ☐ Tingling
- ☐ Aching
- ☐ Deep
- ☐ Shooting

- ☐ Pain worse/better with heat
- ☐ Pain worse/better with pressure
- ☐ Pain worse/better with cold
- ☐ Pain worse in am/pm

I have: *(check all that apply)*

- ☐ Swollen joints
- ☐ Bone pain
- ☐ Repetitive Strain Injury
- ☐ Arthritis/joint pain
- ☐ Muscle cramping
- ☐ Fractured Bone(s): Where? _____
- ☐ Tendonitis
- ☐ Muscle pain

Eyes, Ears, Nose, Throat, & Head

Do you smoke? ☐ No ☐ Yes _____ per day, for _____ years

I have: *(check all that apply)*

- ☐ Frequent colds
- ☐ Chronic cough
- ☐ Pain on inhaling
- ☐ Painful/red eyes
- ☐ Dizziness
- ☐ Dry mouth
- ☐ Clogged/popping in ears
- ☐ Frequent headaches/migraines:
- ☐ Chronic runny nose
- ☐ Coughing blood
- ☐ Asthma
- ☐ Poor vision
- ☐ Cold sores
- ☐ Ear pain
- ☐ Shortness of breath on exertion/at rest
- ☐ Frequent sore throat
- ☐ Cough up mucous
- ☐ Nose bleeds
- ☐ Spots/floaters
- ☐ Bleeding gums
- ☐ Ringing in ears

Cardiovascular

I have: *(check all that apply)*

- ☐ Chest pain
- ☐ Phlebitis
- ☐ Poor circulation
- ☐ Breathlessness
- ☐ Palpitation
- ☐ Cold hands and feet
- ☐ Hypertension
- ☐ Varicose veins
- ☐ Irregular heart beat
- ☐ Hypotension

Skin & Hair

I have: *(check all that apply)*

- ☐ Dry skin
- ☐ Eczema
- ☐ Skin rashes
- ☐ Hives
- ☐ Itching
- ☐ Hair loss
- ☐ Acne
- ☐ Premature graying

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 named 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 tea consumed according to the instructions provided orally and in writing. The herbs may be 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 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.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 the 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.

_____ _____

Patient Signature (or Patient Representative) Date

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.

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, 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 the patient and health care provider and/or other licensed health care providers or preceptorship 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.

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 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 statue 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 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 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.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

OFFICE SIGNATURE DATE