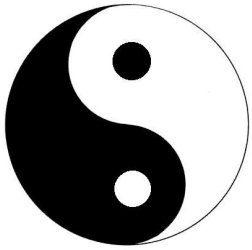

Acupuncture Healing Center, LLC

Name: _____ DOB: _____

Address:_____

Home Phone: _____ Cell: _____ Work: _____

Email: _____

Would you like to receive appointment reminders via text? _____

Employment Status: (check one) ☐ Employed ☐ FT/PT Student ☐ Retired ☐ Other

Employer: _____ How long: _____

Occupation/Title: _____

Please describe your daily work habits and environment:

_____

_____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Other

Emergency Contact Name and phone# _____

How did you hear about me? _____

Please identify the condition(s) that brought you to this office:
Primarily: _____
Secondarily: _____

When and how did the problem(s) begin? _____
When is the problem(s) at its worst? _____
What is the frequency of discomfort? Continuous Intermittent Occasional Frequent
Was the condition treated by anyone in the past? ☐ Yes ☐ No
If yes, by whom? _____ What were the results? _____

Patient Name:_____

Have you had acupuncture before? _____ Chinese Herbal Medicine? _____

Have you ever seen a chiropractor? ☐ Yes ☐ No
If yes, whom? _____ When? _____

Do you currently use tobacco of any kind? Yes / Former User / Never
If yes, how often: current every day current occasional
If yes, what is your level of interest in quitting? (1=not interested – 10= very interested): _____
Do you currently drink alcoholic beverage of any kind? Yes / Former User / Never
If yes, how often: current every day current occasional
If yes, what is your level of interest in quitting? (1=not interested – 10= very interested): _____
Please describe your current fitness routine: _____

_____

Current medications, vitamins, and herbal supplements (frequency and dosage). If none, check here: ☐

	Start Date		Start Date
1)		5)	
2)		6)	
3)		7)	
4)		8)	

List any medicine or environmental allergies you have had. If no allergies are known, check here: ☐

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____
4. _____ Reaction: _____

Please list any major injuries, illnesses, surgeries and treatments you have had or have.

Illness

- ☐ AIDS /HIV Positive
- ☐ Alcoholism
- ☐ Allergies
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Malaria
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sexually transmitted disease
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Headaches

Operations

- ☐ Appendix
- ☐ Bypass surgery
- ☐ Cancer
- ☐ Eye Surgery
- ☐ Hysterectomy
- ☐ Pacemaker
- ☐ Spine: _____
- ☐ Tonsillectomy
- ☐ Vasectomy
- ☐ Physical Therapy
- ☐ Hernia Repair
- ☐ Other: _____

Patient Name:_____

Treatments:

- ☐ Antibiotics
- ☐ Chemotherapy
- ☐ Dialysis
- ☐ Hormone replacement
- ☐ Inhaler
- ☐ Massage

Injuries:

- ☐ Broken bone(s): _____
- ☐ Car accident, (what year): _____
- ☐ Knocked Unconscious
- ☐ Spine disorder
- ☐ Nerve disorder
- ☐ Hernia

Review of Systems

Please check any of the following you have/had in the past:

Musculoskeletal

- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Scoliosis
- ☐ Neck pain
- ☐ Back pain
- ☐ Hip problems
- ☐ Knee problems
- ☐ Foot/Ankle
- ☐ Shoulder issues
- ☐ Elbow/Wrist issues
- ☐ TMJ issues
- ☐ Poor posture

Neurological

- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness
- ☐ Pins & needles
- ☐ Numbness

Cardiovascular

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High cholesterol
- ☐ Poor circulation
- ☐ Excessive bruising
- ☐ Angina

Respiratory

- ☐ Asthma
- ☐ Sleep apnea
- ☐ Emphysema
- ☐ Hay fever
- ☐ Pneumonia
- ☐ Shortness of breath

Digestive

- ☐ Anorexia
- ☐ Bulimia
- ☐ Food sensitivities
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea

Sensory

- ☐ Blurred vision
- ☐ Ears ringing
- ☐ Hearing loss
- ☐ Chronic ear infection
- ☐ Loss of smell
- ☐ Loss of taste

Integumentary

- ☐ Skin cancer
- ☐ Psoriasis
- ☐ Eczema
- ☐ Acne
- ☐ Rash
- ☐ Hair loss

Endocrine

- ☐ Thyroid issues
- ☐ Immune disorders
- ☐ Hypoglycemia
- ☐ Frequent infection
- ☐ Swollen glands
- ☐ Low energy

Genitourinary

- ☐ Kidney stones
- ☐ Infertility
- ☐ Frequent urination
- ☐ Prostate issues
- ☐ Erectile dysfunction
- ☐ PMS symptoms

Constitutional

- ☐ Fainting
- ☐ Low libido
- ☐ Fatigue
- ☐ Weakness
- ☐ Sudden weight loss or gain (circle one)
- ☐ Poor appetite

Does anyone in your family suffer with the same condition(s)?: No Yes

If yes, whom and which condition(s): _____

_____

Acupuncture Healing Center, LLC

Patient Questionnaire

Please list the family members or other persons, if any, whom we may inform about your general medical condition and/or your TCM diagnosis (including treatment, payment and health care operation):_____
_____

Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name_____ Phone Number_____

Name_____ Phone Number_____

Please print the address of where you would like your billing statements and/or correspondence from our office to be sent IF OTHER THAN YOUR HOME:

Street/P.O. Box _____

City/State/ZipCode_____

Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

YES_____ NO_____

_____ I give my consent to be contacted by via phone, text and or email.

Can confidential messages (ie: appointment reminders) be left on your telephone answering machine or voicemail?

YES_____ NO_____

Please print the telephone number where you want to receive calls about your appointments, lab results, or other health care information IF OTHER THAN YOUR HOME PHONE NUMBER: _____

May we contact your physician to discuss your diagnosis and/or any other pertinent information, as needed?

If YES, Please provide physician's name and number _____

Would you like to receive information about upcoming events, open houses, newsletters and/or other information on Chinese Medicine via email?

YES_____ Email address:_____
NO _____

PATIENT NAME (please print) _____

PATIENT/GUARDIAN SIGNATURE _____ 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. 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 arbitratidr:i. 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-economiclosses, 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.

PATIENT SIGNATURE X _____ (Date)

(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 pot(tfltial 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 nee<!_les 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 traditionallyconsidered 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:

PATIENT SIGNATURE **X** (Date)

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE