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**PATIENT INFORMATION**

**General Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone – Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Sex:  Male  Female      Marital Status:  Married  Single  Divorced  Widowed

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Primary Health Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may I thank for referring you? \_\_\_\_\_

**Health Care Information**

Primary Complaints: \_\_\_\_\_

Have these complaints been previously diagnosed? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please answer the following questions:

1. Do you tend to faint?  Yes  No
2. Do you have a pacemaker?  Yes  No
3. Do you tend to bleed for a long time?  Yes  No
4. Do you smoke?  Yes  No How much? \_\_\_\_\_
5. Do you drink alcohol?  Yes  No How much? \_\_\_\_\_
6. Do you drink caffeinated beverages?  Yes  No How much? \_\_\_\_\_
7. Do you exercise regularly?  Yes  No Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. Do you use drugs for non-medical purposes?  Yes  No Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

9. Please list all medications, vitamins and herbs that you have taken in the past three months:

\_\_\_\_\_

\_\_\_\_\_

10. Please list all injuries, surgeries and major illnesses you have had, including dates: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **Patient Medical History**

Please check any symptoms that you have experienced in the past three months.

### **Musculoskeletal (*pain, weakness, numbness*)**

- |                                    |                                      |
|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Arms      | <input type="checkbox"/> Neck        |
| <input type="checkbox"/> Hands     | <input type="checkbox"/> Upper Back  |
| <input type="checkbox"/> Shoulders | <input type="checkbox"/> Middle Back |
| <input type="checkbox"/> Feet      | <input type="checkbox"/> Lower Back  |
| <input type="checkbox"/> Legs      | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hips      |                                      |

## **Patient Medical History (continued - page 1)**

### **Cardiovascular**

- Chest Pain
- High Blood Pressure
- Low Blood Pressure
- Irregular Heart Beat
- Palpitations
- Poor Circulation
- Dizziness
- Edema

### **Gastrointestinal**

- Indigestion
- Abdominal Pain
- Constipation
- Diarrhea
- Heartburn
- Bloating
- Gas
- Belching
- Nausea
- Vomiting
- Hemorrhoids
- Excessive Appetite
- Decreased Appetite
- Colitis/IBS
- Gallbladder Problems

### **Eyes/Ear/Nose/Throat/Respiratory**

- Cough
- Sore Throat
- Nasal/Sinus Congestion
- Frequent Colds
- Enlarged Glands
- Nose Bleeds
- Asthma/Wheezing
- Hay Fever
- Bronchitis
- Shortness of Breath
- Blurred Vision
- Eye Pain
- Earache
- Loss of Hearing
- Ringing in the Ears

### **Urogenital**

- Frequent Urination
- Painful Urination
- Lack of Bladder Control
- Kidney Stone/Infections
- Genital Pain
- Venereal Disease
- Decreased Sex Drive

### **Skin**

- Bruise Easily
- Rash/Itching
- Dry Skin
- Acne
- Edema
- Boils
- Slow Healing Wounds

## **Patient Medical History** *(continued - page 2)*

### **Men Only**

- Prostate Problems
- Erection Problems
- Pain in Testicles

### **Women Only**

- |   |   |
|---|---|
| <input type="checkbox"/> Menstrual Pain/Cramps    | <input type="checkbox"/> Excessive Menstrual Flow |
| <input type="checkbox"/> Irregular Periods        | <input type="checkbox"/> Breast Swelling/Pain     |
| <input type="checkbox"/> Bleeding Between Periods | <input type="checkbox"/> Moodiness                |
| <input type="checkbox"/> Clots in Menses          | <input type="checkbox"/> Miscarriage              |

### **Miscellaneous**

- |   |  |
|---|--|
| <input type="checkbox"/> Depression     | <input type="checkbox"/> Easily Startled |
| <input type="checkbox"/> Anxiety        | <input type="checkbox"/> Excessive Anger |
| <input type="checkbox"/> Dizziness      | <input type="checkbox"/> Excessive Fear  |
| <input type="checkbox"/> Fever          | <input type="checkbox"/> Irritability    |
| <input type="checkbox"/> Poor Memory    | <input type="checkbox"/> Nervousness     |
| <input type="checkbox"/> Headache       | <input type="checkbox"/> Overwhelmed     |
| <input type="checkbox"/> Loss of Sleep  | <input type="checkbox"/> Other _____     |
| <input type="checkbox"/> Loss of Weight | _____                                    |
| <input type="checkbox"/> Sweating       | _____                                    |

## **Family Medical History**

Please indicate any disease that has been in your family and which family member was effected.

- Diabetes \_\_\_\_\_
- Cancer \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- Seizures \_\_\_\_\_
- Asthma \_\_\_\_\_
- Allergies \_\_\_\_\_
- Arthritis \_\_\_\_\_
- Other \_\_\_\_\_

## **Cancellations and Missed Appointments**

I respect that you may occasionally need to cancel an appointment, however, I request the standard 24 hour notice. Should you cancel an appointment with less than 24 hours notice, or not show up for a scheduled appointment, a charge equal to your last appointment will be applied to your account. Thank you for your understanding.

The information on this form is correct and to the best of my knowledge.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature (if patient is under 18) \_\_\_\_\_ Date: \_\_\_\_\_

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 California 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 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 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 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 the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). 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 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)

OFFICE SIGNATURE **X** (Date)

**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 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 teas 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 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.

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 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.

(Date)

PATIENT SIGNATURE

X

(Or Patient Representative)

(Indicate relationship if signing for patient)

**ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE**