Sharp's Point South, Suite 202W
75 Mechanic Street
Rockland, ME 04841
207-332-9941

Patient Intake Packet

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out these 9 pages of information carefully. All of your information will be kept confidential. If you have questions, please ask.

Date: ________________

Last Name: ____________________________ First Name: ______________________________

Nickname/Preferred Name: _________________________________ Gender:_________________

Birth date: __________ Age: ______ Relationship Status: _______________ Children: ________

Occupation: ____ Usually Work Indoors Outdoors

Address: __________________________ City: _____________ State: _____Zip: ___________

Email Address: ____

Phone: (Home)_________________(Work)__________________ (Cell) ____________________

Preferred method for receiving appointment reminders? ☐Text ☐Email ☐Other _______________

Family Physician: __________________________________ Did s/he refer you? ______________

Have you been treated by acupuncture or Oriental medicine before? ☐Yes ☐No

How did you find out about us? ☐Friend/relative (Name) __________________________________

☐ Ad (Where?) _______________________ ☐Card/Brochure (Where?) ___________________

☐ Website ☐Facebook ☐ Other ____

Emergency Contacts

Name: ___________________ Relationship: __________________ Phone: __________________

Name: ___________________ Relationship: __________________ Phone: __________________

Name: ___________________ Relationship: __________________ Phone: __________________

Health History Questionnaire

Please list the primary reasons for your visit:	Date of Onset	Frequency	Intensity (1-10)
1.		Always Intermittent	
2.		Always Intermittent	
3 .		Always Intermittent	

With which aspects of your daily life do these problems interfere? Work Play/Exercise Sleep
Standing Sitting Walking Bending Stretching Emotional Social/Relationships
Other____

What do you believe are the causes for these problems? ________________________________
____
____
____
____

What makes each problem better? ____
____
____
____

What makes each problem worse? ____
____
____
____

What kind of treatment(s) have you tried to solve these problems? ________________________
____
____
____

Is there anybody in your family with the same/similar problem(s)__________________________
____
____

What, if any, medical diagnosis have you been given for your symptoms? ___________________
____
____
____
____

What are your goals for receiving acupuncture? Check all that apply:

- ☐ stress relief
- ☐ reduction in symptoms or pain: To what percentage? ________%
- ☐ complete disappearance of symptoms or pain
- ☐ no expectation for improvement: Why? ____
- ☐ greater flexibility
- ☐ better posture
- ☐ illness prevention

Would you like to learn more about? Custom Chinese herbal formulas Digestive supplements Nutrition
Sotai Ho Stretching & Movement education/self-care Stress reduction techniques Life coaching

Medications w/in the last 2 months (prescription & over the counter drugs, vitamins, herbs, supplements, etc.):

____

Allergies (drugs, chemicals, food, environmental)**:** ______________________________

Surgeries / Hospitalization (Please include dates, Approximate OK): ______________________

Significant Trauma {accidents, injuries, falls, emotional/sexual abuse, etc.} (Please include dates. Approximate OK): ______________________________

Do you have any reason to believe you may be pregnant? □Yes □No
If so, how far along are you? ______________________________

Do you have any infectious diseases? □Yes □No If yes, please identify: ______________

Height ____ Weight ____ Past Maximum ____ When? _____

Approximately what are your vital signs: Blood pressure ____/ ____ Heart Rate____Breaths/min____
When was the last time you had these readings taken? ____________

Lifestyle

Do you typically eat three meals per day? ☐ Yes ☐ No If no, how many? _________
Please describe a typical day's food and drink intake: ______________________________

How often do you exercise? ☐ everyday ☐ 5-6x/wk ☐every other day ☐2-3x/wk ☐1x/wk ☐ Never
What kinds of exercise do you do? ______________________________

How many hours per night do you sleep? ______ Do you wake rested? ☐ Yes ☐ No

Level of Education completed: ☐High School ☐College ☐MA/MS ☐PhD ☐ Other______________

Do you use/do any of the following potentially habit forming substances/activities? ☐ Nicotine ☐Alcohol ☐Caffeine ☐ Sugar ☐Recreational Drugs ☐ TV / Digital Media / Gaming

If yes, how do you feel about your habits? ____

____

____

____

How many hours / week do you work? ________ Do you enjoy your work? ☐ Yes ☐ No

Why/Why not? ____

____

____

____

Spiritual Practice: ____

____

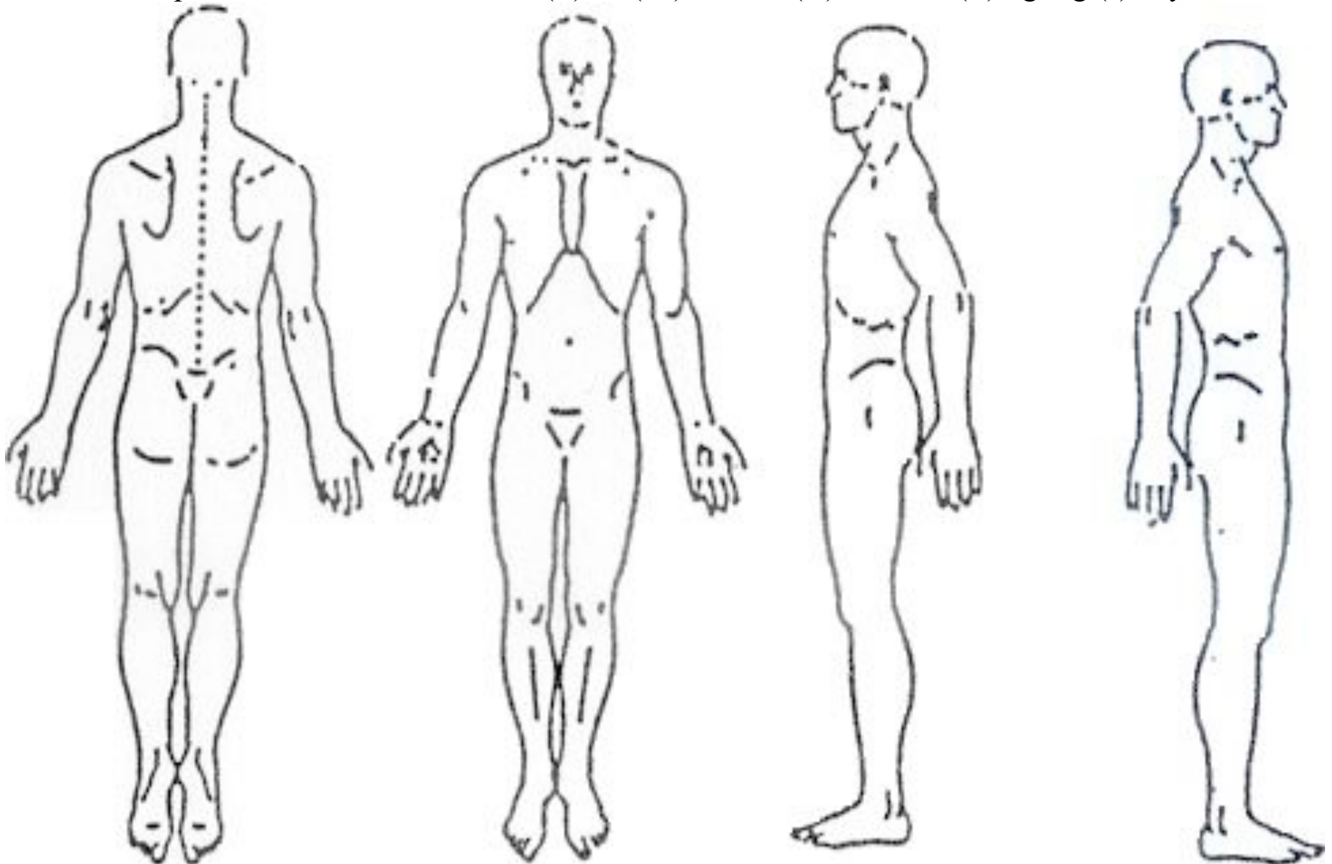
Hobbies/Volunteer Activities: ____

____

____

____

Please circle problem areas and indicate: (**P**)ain (**W**)eakness (**N**)umbness (T)ingling (**I**)tchy



PLEASE CHECK IF YOU HAVE BEEN EXPERIENCING ANY OF THE FOLLOWING (last 3 months):

NEUROPSYCHOLOGICAL

□Seizures/Epilepsy	□Numbness/Tingling	□Anxiety
□Concussion	□Lack of Coordination	□Poor Memory
□Dizziness/Vertigo	□Loss of Balance	□Easily Angered
□Headaches	□Fainting	□Depression
□Migraines	□Disorientation	□Mood Swings
□Nervousness	□ Tension	□Stress

ENERGY AND IMMUNITY

□Fatigue □Slow Wound Healing □Chronic Infections Recurrent Colds/Flus

EYE EAR NOSE AND THROAT

□Impaired Vision □EyePain/Strain □Glaucoma □Glasses/Contacts □Tearing/Dryness
□Impaired Hearing □Ear Ringing □Earaches Phlegm ☐Allergies □Hay Fever
□Sinus Problems □Nose Bleeds Nasal Congestion □Frequent Sore Throats
□Teeth Grinding Teeth Sensitivity □TMJ/Jaw Problems Mouth Sores

RESPIRATORY

□ Pneumonia □Difficulty Breathing □Emphysema □ Cough □Pain with Deep Breath
Coughing Blood □Asthma □Tuberculosis □Shortness of Breath Phlegm

CARDIOVASCULAR

□Heart Disease	□Chest Pain	□Swelling of Feet/Ankles
□High Blood Pressure	□Palpitations/Fluttering	□Stroke
□Heart Murmurs	□Rheumatic Fever	□Varicose Veins
Fainting	Blood Clots	

GASTROINTESTINAL

□Ulcers	□Changes in Appetite		□Nausea/Vomiting
□Epigastric Pain	□Passing Gas		□Heartburn
□Belching	□ Hiccups		□Bad Breath
□Hepatitis B or C	□ Gall Bladder Attack		□Abdominal Pain
☐ Liver Disease	□ Diarrhea	□ Constipation	☐Hemorrhoids

# of Bowel Movements ___/ □day □week Usual time(s):____

Soft Stool Dry/Hard Stool Blood in Stool Black Stool Mucous in Stool
Abdominal Pain & Cramps

GENITO-URINARY

□Kidney Disease	□Painful Urination	□Frequent UTI
□Frequent Urination	□Heavy Flow	□Kidney Stones
□Infrequent Urination	□Blood in Urine	□Wake to Urinate
Urgent Urination	Unable to hold urine	Decrease in flow

FEMALE

☐Irregular Cycles ☐Breast Lumps ☐Breast Tenderness ☐Nipple Discharge
☐Heavy Flow ☐Vaginal Discharge ☐Premenstrual Problems
☐Clotting ☐Bleeding Between Cycles ☐Menopausal Symptoms
☐Painful Periods Yeast Infection Genital Sores

Date of Last Period _______ Duration of Menses: _______ Length of Cycle: _______

☐Difficulty Conceiving Use birth control (What type?):_____________________________

# of Pregnancies:_____ #of Live Births:_____ #of Miscarriages:_____

# of difficult deliveries_____ # of C-sections ______ # of premature births______

Age of First Menses:_____ Age of Menopause: ______

MALE

☐Erectile Dysfunction ☐Prostrate Problems ☐Testicular Pain/Swelling
Impotence ☐Premature Ejaculation ☐Penile Discharge Genital Sores

MUSCULOSKELETAL PAIN & DYSFUNCTION

☐Head ☐Jaw ☐Neck Shoulder
☐Arm Elbow Wrist Hand
☐Upper Back ☐Mid Back ☐Low Back Sacrum Tailbone
Hip ☐Leg Sciatica Knee Ankle Foot

ENDOCRINE

☐Hypothyroid ☐Hyperthyroid ☐Hypoglycemia
☐Diabetes Mellitus ☐Night Sweats Feeling Hot Cold

SKIN/NAILS/HAIR

☐Eczema Psoriasis Hives Rashes Shingles Acne ☐itching
Other Skin Conditions:____
Fungal Growth: Where? Foot Groin Other ________________________
☐Loss of hair ☐ dry hair brittle nails thickening nails

OTHER

☐Anemia ☐Cancer ☐Rashes Sweat Easily Gout Cravings Poor Appetite Strong Thirst
Weight gain Weight loss Fever/Chills Bruise easily ☐Low Libido ☐Excessive Libido
☐Cold Hands/Feet ☐Hot Flashes E\

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Consent to Treatment Form

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Moxibustion: I understand that direct moxibustion is commonly used with the Seitai Shinpo treatment. This involves burning the herb Artemisia Vulgaris on acupuncture points on the skin. The application of moxibustion may become uncomfortable as it produces a heat sensation and could leave a small blister or scab on the surface of the skin. As with any part of treatment, if it becomes too uncomfortable I am free to notify the practitioner. With particular skin types there is a risk of scarring from its use, however shiunko oil will be administered directly on the skin to minimize scarring.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call my practitioner as soon as possible.

Cupping/Gua Sha: I understand that the techniques of cupping or gua sha may produce a redness of the skin which may persist for 3-4 days, and may result in slight bruising or tenderness. The red discoloration is a sign of increased blood circulation.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture or similar techniques administered with acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Healing Reaction: I understand that in the natural healing system of acupuncture, the rebalancing of energy may result in a temporary worsening of symptoms, commonly referred to as a Healing Reaction, which may include symptoms such as dizziness, nausea, loss of appetite, slight fever, heavy head, and fatigue. The best treatment for this reaction is rest, and commonly the symptoms go away in a few days. I agree to contact my acupuncturist if my condition worsens.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment

Signature: ____ **Date:** ________________________
Printed Name:

tobeywilliamson@hotmail.com
goodhearth-acupuncture.com
www.facebook.com/goodhearthacupuncture

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Privacy Policy

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I understand that as part of my healthcare, Good Hearth: Eastern Medical Arts originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment. This information may be used to consult with other Seitai Shinpo practitioners anonymously only for educational purposes and to ensure appropriate diagnosis and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that Good Hearth: Eastern Medical Arts is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that Good Hearth: Eastern Medical Arts has already taken action in reliance thereupon.
- To request copies of my protected health information, and that Good Hearth: Eastern Medical Arts has the right to charge you a small fee for the staff time and resources required to fulfill such request.

I request the following restrictions to the use of disclosure of my health information:

____

____

I have read and understand my rights regarding privacy of information and under which conditions this information is shared with others so that I may receive therapy and that any claims may be made on my behalf (only for insurance purposes).

Signature: ______________________________ **Date:** ________

Print Name: ____________________

A copy of your patient rights is available upon request.

tobeywilliamson@hotmail.com
goodhearth-acupuncture.com
www.facebook.com/goodhearthacupuncture

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.

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.

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

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24-Hour Appointment Cancellation Policy

Good Hearth Eastern Medical Arts has a 24 hour cancellation and/or rescheduling policy.

If you miss your appointment, cancel or change your appointment with less than 24 hours notice, and we are unable to fill the time with another patient, you will either be charged the full cost of your scheduled treatment /consultation or have 1 treatment/consultation session deducted from any prepaid treatment package of treatments/consultations.

Initial ____

This policy is in place out of respect for our therapists and our patients.

Cancellations with less than 24 hours notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot and receive the care they need.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Good Hearth Eastern Medical Arts as described above.

Thank you for your understanding and cooperation.

______________________________ ______________________________
Printed Name Signature

____
Date

tobeywilliamson@hotmail.com
goodhearth-acupuncture.com
www.facebook.com/goodhearthacupuncture