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Initial Intake Form

Thank you for taking the time to complete the following information which will help me assess your health needs. All information is confidential. I will be happy to answer any questions.

Name ______________________ Age ________ Birth Date ______________

Address ____

City ______________________________ State __________Zip ____________

Phone ______________________ E-mail______________________

Employer ______________ Occupation ______________ Hours you work per week ________

Emergency Contact: ______________________ Phone: ______________________

Reason for visit today? ____

____

How long have you had this condition? ______________________________

Is it getting worse? ____

What seemed to be the initial cause? ______________________________

____

What seems to make it better? ______________________________

____

What seems to make it worse? ______________________________

____

Whom should we thank for referring you to our office? ______________________________

Have you had acupuncture therapy before? ❒ Yes ❒ No

Check those that apply to your past medical history:

❒ Adverse reaction to medical treatment
❒ Alcoholism
❒ Allergies
❒ Arthritis or rheumatism
❒ Asthma
❒ Attempted suicide
❒ Birth Trauma
❒ Bleeding disorder
❒ Blood disease
❒ Cancer or tumor
❒ Diabetes
❒ Emphysema
❒ Eating disorder
❒ Fibromyalgia
❒ Heart disease
❒ Hepatitis/Liver disease
❒ Herpes
❒ High blood pressure
❒ HIV/AIDS
❒ Immune disorder
❒ Joint replacement
❒ Kidney disorder
❒ Low blood pressure
❒ Lyme's disease
❒ Lymph nodes removed
❒ Mental illness
❒ Multiple Sclerosis
❒ Pacemaker
❒ Polio
❒ Rheumatic arthritis
❒ Rheumatic fever
❒ Sciatica
❒ Scarlet fever
❒ Seizures/Epilepsy
❒ Sinus infections
❒ Skin disease
❒ Special diet
❒ Stroke
❒ Substance abuse
❒ Thyroid disease
❒ Tuberculosis
❒ Ulcer
❒ Venereal Disease/STD
❒ Other__________________

List any serious diseases, injuries, surgeries, or hospitalizations you have had and the year they occurred:

____

____

____

Please indicate approximate dates and briefly describe the nature of any traumatic experiences you have had (e.g. divorce, injury, family death, bankruptcy, etc).

Date____/______Event ______________________ Date____/______ Event ______________________

Date____/______Event ______________________ Date____/______ Event ______________________

Date____/______Event ______________________ Date____/______ Event ______________________

Family History (List any family physical or mental illnesses and age of death):

Mother ____

Father ____

Grandparents____

Siblings ____

Children ____

Medications, Herbs, Supplements (List those you are currently taking):

Name________________Reason ______________How long and Dose ______________

Name________________Reason ______________How long and Dose ______________

Name________________Reason ______________How long and Dose ______________

Name________________Reason ______________How long and Dose ______________

Name________________Reason ______________How long and Dose ______________

Describe your typical daily diet:

Breakfast_____________________ Lunch_____________________

Dinner_______________________ Snacks ____________________

Special diet___________________ 3 worst foods you eat___________________

Do you:	Yes	No	
Average 6 - 8 hours sleep?			What is the major source of joy inyour life? ______________________
Have a supportive relationship?			
Have a history of abuse?			
Enjoy your work?			What is the major source of stress inyour life?______________________
Take vacations?			
Spend time outdoors?			
Exercise?			*Describe exercise:*
Watch TV?			*How many hours weekly:*
Read books?			*How many hours weekly:*
Computer games / browsing?			*How many hours weekly:*
Spiritual / religious practice?			*Describe:*
Smoke cigarettes?			*How much:*
Smoke cigarettes in the past?			*How many years:* *Packs a day:*
Eat out often?			*How many meals a week?*
Drink coffee?			*How many cups a day?*
Drink tea?			*How many cups a day?*
Drink soft drinks?			*How many a day?*
Use sugar?			*How much?*
Drink alcohol?			*How many drinks a week?*
Use recreational drugs?			*What and how often?*
Have an addiction?			*To what and how long?*
Been outside the U.S. in past 12 months?			*Where?*

What are your goals for your health?

____

____

____

Please circle your level of commitment to correcting your health issues? (10 = highest level)

1 2 3 4 5 6 7 8 9 10

Please list your major health concerns in order of importance to you: ______________________

____

____

____

Please mark the appropriate squares in the following list of symptoms.
If you have had a symptom in the PAST and do not have it now, check the box like this: ☑
If you are having the symptom CURRENTLY, fill in the box like this: ■

Liver/Gallbladder
- ❐ Depression / Stress
- ❐ Headaches / Migraines
- ❐ Red / Dry / Itchy Eyes
- ❐ Visual Problems / Blurred vision
- ❐ Dizziness
- ❐ Gall Stones
- ❐ Feeling of Lump in Throat
- ❐ Clenching Teeth at Night
- ❐ Muscle Cramping / Twitching
- ❐ Neck/Shoulder Pain / Tightness
- ❐ Seizures/Tremors
- ❐ Poor Circulation
- ❐ Soft/Brittle Nails
- ❐ Bitter Taste in Mouth
- ❐ PMS/Menstrual Problems
- ❐ Tendonitis
- ❐ Pain Below Ribcage
- ❐ Do you crave: Sour
- ❐ Tend to be Irritable / Angry
- ❐ insomnia between 1-3am

Heart/Small Intestine
- ❐ Heart Palpitations
- ❐ Rapid or Irregular Heartbeat
- ❐ Chest Pain
- ❐ High Blood Pressure
- ❐ Low Blood Pressure
- ❐ Insomnia / Sleep Problems
- ❐ Vivid Dreams / Nightmares
- ❐ Easily Startled
- ❐ Dark Urine
- ❐ Red Complexion
- ❐ Do you crave: Bitter
- ❐ Anxiety / Nervous or Restless

Spleen/Stomach
- ❐ Body Heaviness
- ❐ Hard to get up in Morning
- ❐ Muscles Often Feel Tired
  ___ Energy Level: 1-10 (low to high)
- ❐ Edema (❐ Hands ❐ Feet)
- ❐ Easily Bruising / Bleeding
- ❐ Bad Breath
- ❐ Sweetish Taste in Mouth
- ❐ Lack of Taste
- ❐ Excess or Low Appetite (circle which)
- ❐ Excess or Lack of Thirst (circle which)
- ❐ Nausea / Vomiting
- ❐ Gas / Belching
- ❐ Hemorrhoids
- ❐ Organ Prolapse (i.e. uterus)
- ❐ Chronic Loose Stools
- ❐ Abdominal Pain
- ❐ Indigestion / Heartburn
- ❐ Brain Foggy
- ❐ Mouth Ulcers
- ❐ Tendency to Gain Weight
- ❐ Do you crave: Sweet
- ❐ Over-thinking / Worry

Lung/Large Intestine
- ❐ Bloody Cough
- ❐ Dry Cough
- ❐ Chronic Cough
- ❐ Cough with Sputum
- ❐ Nasal Discharge
  ❐ White ❐ Yellow ❐ Green
- ❐ Post Nasal Drip
- ❐ Sinus Infection / Congestion
- ❐ Itchy, Red, or Painful Throat
- ❐ Dry Mouth / Nose / Throat
- ❐ Skin Rashes / Hives
- ❐ Snoring
- ❐ Shortness of Breath
- ❐ Allergies / Asthma
- ❐ Low Immunity
- ❐ Catch Colds Easily
- ❐ Bronchitis
- ❐ Black or Bloody Stools
- ❐ Constipation
- ❐ IBS
- ❐ Diarrhea
- ❐ Colitis / Spastic Colon
- ❐ Do you crave: Pungent / Spicy
- ❐ Grief / Sadness

Kidney/Urinary Bladder
- ❐ Urinary Problems (i.e. night-time)
  ____
- ❐ Bladder Infection
- ❐ Incontinence
- ❐ Weakness / Pain in Low Back
- ❐ Osteoporosis
- ❐ Feel Cold or Hot Easily (circle which)
- ❐ Cold Hands / Feet
- ❐ Low or Excess Sex Drive (circle which)
- ❐ Dark Circles under Eyes
- ❐ Thyroid Problems
  ____
- ❐ Poor Memory
- ❐ Hair Loss / Grey Hair
- ❐ Hearing Problems / Tinnitus
- ❐ Cavities
- ❐ Hot Flashes / Night Sweats
- ❐ Impotence or Premature Ejaculation (circle which)
- ❐ Do you crave: Salt
- ❐ Fear

INFORMED CONSENT & DISCLOSURE

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, herbal medicine, moxibustion, cupping, electrical stimulation, medical qigong, massage, gua sha, heat therapy, ear seeds, dietary advice, qigong exercise prescriptions, and lifestyle counseling. I understand that acupuncture, moxibustion, electrical stimulation, cupping and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Very unusual risks of acupuncture include dizziness, fainting, nerve damage, or pneumothorax. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential but unlikely risks of moxibustion are burns, blistering, or scarring.

Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. I also understand that certain social habits and medications may decrease the beneficial effects of Chinese medical treatment. These include the use and abuse of alcohol, pain killers, steroids, narcotics, tobacco, anti-depressants, and illegal drugs.

Acupuncture is a natural medicine that works with the body's ability to heal itself, but is not a substitute for conventional medical diagnosis and treatment. The results of acupuncture are not always felt immediately, especially with chronic conditions. Frequentregular treatment is what gives acupuncture and herbs the best results. I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice. I also certify that I have informed my acupuncturist of all known physical, mental and medical conditions and medications, and I will keep her updated on any changes.

____________________________________ ________________________

Patient Signature Date

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 ntended 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 ______________________ Date ______________________

MISSED APPOINTMENT POLICY

If you need to change or cancel your appointment please do so within 24 hours notice. Failure to do so will result in being charged full price for missed appointment.

(Initial here)______ I understand the cancellation policy.