

Patient Intake Form

Name:	Phone: Home	Cell: _____
Street	Age Ht.	Wt.
City	Birthdate	Sex
State Zip	Occupation:	
Physician:	Referred By:	Emerg. #:
Main Problem:		Onset:
Other Concurrent Therapies	Email: _____	

Past Medical History (include date):

Significant Illnesses: ___ Cancer ___ Diabetes ___ High Blood Pressure ___ Heart Disease ___ Hepatitis
 ___ Rheumatic Fever ___ Thyroid Disease ___ Seizures ___ Other.

Surgeries:

Significant Trauma (auto accidents, falls, etc.)

Birth History: (prolonged labor, forceps delivery, etc.)

Allergies: (drugs, chemicals, foods.)

Medicines taken within the last two months (include vitamins, over-the-counter drugs, herbs, etc.)

Occupational Stresses (Chemical, physical, psychological, etc.)

Exercise:

Comments:

Average daily diet:

Morning

Afternoon

Evening

Habits: Cigarettes Coffee Tea Cola Alcohol Drugs Sugar Salt Other _____

Family Medical History: ___ Diabetes ___ Cancer ___ High Blood Pressure ___ Heart Disease ___ Stroke ___ Seizures
 ___ Asthma ___ Allergies ___ Alcoholism ___ Other _____

Notes _____

GENERAL

- | | | | |
|----------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Heavy sleep |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Tremors | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Cold back | <input type="checkbox"/> Cold abdomen |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Sudden energy drop at _____ (time) | <input type="checkbox"/> Peculiar tastes/smells _____ | | |
| <input type="checkbox"/> Strong thirst (cold/hot drinks) _____ | <input type="checkbox"/> Bleed or bruise easily (where) _____ | | |

SKIN AND HAIR

- | | | | |
|------------------------------------------------------|--------------------------------------|-----------------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair |
| <input type="checkbox"/> Change in hair/skin texture | <input type="checkbox"/> Purpura | <input type="checkbox"/> Other hair or skin problem _____ | |

HEAD, EYES, EARS, NOSE, AND THROAT

- | | | | |
|------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Night blindness |
| <input type="checkbox"/> Color blindness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Mucus | <input type="checkbox"/> Dry throat | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Copious saliva |
| <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Jaw clicks | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Gum problems | <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> Recurrent sore throats _____/month | |
| <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Headaches (where and when) _____ | | |
| <input type="checkbox"/> Other head or neck problems | | | |

CARDIOVASCULAR

- High blood pressure
- Dizziness
- Blood clots
- Low blood pressure
- Fainting
- Phlebitis
- Chest Pain
- Cold hands/feet
- Difficulty breathing
- Irregular heartbeat
- Swelling in hands/feet
- Other _____

RESPIRATORY

- Cough
- Pneumonia
- Production of phlegm _____ what color _____
- Coughing blood
- Difficulty in breathing when lying down
- Asthma
- Bronchitis
- Tight chest
- Other lung problems

GASTROINTESTINAL

- Nausea
- Gas
- Bad Breath
- Constipation
- Pain or cramps
- Vomiting
- Belching
- Rectal pain
- Bloody stools
- Laxative use: _____ /week; type _____
- Diarrhea
- Black stools
- Hemorrhoids
- Sensitive abdomen
- Bowel Movement:
 - _____ Frequency
 - _____ Color
 - _____ Odor
 - _____ Texture/form

GENITO-URINARY

- Pain on urination
- Unable to hold urine
- Wake up to urinate
- Frequent urination
- Kidney stones
- How often _____ /night; time: _____
- Blood in urine
- Venereal disease
- Urgency to urinate
- Impotency
- Other G/U problems

PREGNANCY AND GYNECOLOGY

- Number pregnancies
- Age at first menses
- Flow (describe)
- Vaginal discharge
- Birth control type and duration _____
- Number births
- Period (days)
- Clots
- Vaginal sores
- Premature births
- Duration
- Last PAP _____
- Breast lumps
- Changes in body/psyche prior to menstruation
- Miscarriages
- Irregular periods _____
- Last menses _____
- Menopause _____

MUSCULOSKELETAL

- Neck pain
- Other joint or bone problems?
- Muscle pains
- Back pain(where) _____
- Joint pains(where) _____

NEUROPSYCHOLOGICAL

- Seizures
- Depression
- Treated for emotional problems
- Other neurological or psychological problems?
- Areas of numbness
- Anxiety
- Poor memory
- Bad temper
- Concussion
- Easily stressed
- Considered/attempted suicide

CLASSICAL

Preference	Most Liked	Least Liked
Season		
Taste		
Climate		
Time of Day		
Temperature		

- Body type: _____
- Color: _____
- Tone: _____
- Odor: _____
- Yin/Yang: _____
- Firm/Weak: _____
- Hot/Cold: _____
- Surface/Interior: _____

COMMENTS

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 2 OF 2 - PLEASE SIGN BOTH SIDES

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 (Oriental massage), Oriental 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. 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. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect 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 Oriental 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.

PATIENT SIGNATURE X (Or Patient Representative)	Date (Indicate relationship if signing for patient)
----------------------------------------------------	------------------------------------------------------------

OFFICE SIGNATURE	Date
------------------	------

PLEASE SIGN REVERSE SIDE ALSO

PATIENT NAME

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 1 OF 2 - PLEASE SIGN BOTH SIDES

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, and 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 or preceptorship interns who now or in the future treat 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 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 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) _____
(Or Patient Representative) (Indicate relationship if signing for patient)

PLEASE SIGN REVERSE SIDE ALSO