Harmony Community WELLNESS CENTER

Health History Questionnaire and Registration

Patient Information

Date: _____

Name: _____

Address: _____

City / Zip: _____

Age: _____ Birthdate: _____

Occupation: _____

Company Name: _____

Primary Physician: _____

Physician Phone No.: _____

How did you hear about us? _____

_____

Contact Information

Home Phone: _____

Work Phone: _____

Other/Cell: _____

Email: _____

Your email address will be used to send appointment reminders, event information and clinic news. It will never be given to a 3rd party.

Another person we may contact if needed:

Name: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Health History

What are your primary concerns for coming in for treatment?

1) _____

2) _____

3) _____

How is your sleep? _____

_____

How is your digestion? _____

_____

List medications or food supplements you are taking.

_____

_____

_____

Do you wear a pacemaker? Yes No

List serious illnesses, accidents or surgeries:

_____

_____

_____

Check illnesses that have occurred in blood relatives:

- ❑ Cancer
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Heart Disease
- ❑ Kidney Disease
- ❑ Seizures
- ❑ Stroke
- ❑ Tuberculosis

How long has it been since you have had a complete medical examination? _____

Check **conditions** you have or have had in the past:

- ❑ Aids/HIV
- ❑ Allergies
- ❑ Anemia
- ❑ Arthritis
- ❑ Bleeding disorders
- ❑ Breast cysts
- ❑ Cancer
- ❑ Colitis
- ❑ Diabetes
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Heart Disease
- ❑ IBS
- ❑ Kidney Disease
- ❑ Seizures
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Other _____

Check **symptoms** you have or have had in the past year:

- ❑ Anxiety
- ❑ Depression
- ❑ Difficulty in focusing
- ❑ Dizziness
- ❑ Easily startled
- ❑ Excessive worry
- ❑ Excessive anger
- ❑ Excessive fear
- ❑ Fatigue/tiredness
- ❑ Headaches
- ❑ Insomnia
- ❑ Irritability
- ❑ Loss or gain of weight
- ❑ Muscle Tension
- ❑ Nervousness
- ❑ Overwhelmed by life
- ❑ Stress

Health History ….. continued

Check **symptoms** you have:

MUSCLE/BONE/JOINTS

- ❑ Tremors
- ❑ Cramps
- ❑ Swollen Joints
- ❑ Restless Leg

Pain, weakness, numbness

- ❑ Neck
- ❑ Shoulders
- ❑ Arms
- ❑ Hands
- ❑ Other _____
- ❑ Back
- ❑ Hip
- ❑ Legs
- ❑ Feet

EYES/EAR/NOSE/THROAT/RESPIRATORY

- ❑ Asthma/wheezing
- ❑ Blurred/failing vision
- ❑ Cough/sore throat
- ❑ Hearing loss
- ❑ Earache
- ❑ Enlarged glands
- ❑ Eye pain
- ❑ Frequent colds
- ❑ Other _____
- ❑ Hay fever
- ❑ Hoarseness
- ❑ Gum bleeding
- ❑ Labored breathing
- ❑ Nose bleeds
- ❑ Persistent cough
- ❑ Ringing in ears
- ❑ Sinus problems

SKIN

- ❑ Acne
- ❑ Boils
- ❑ Bruise easily
- ❑ Dandruff
- ❑ Dry skin
- ❑ Eczema
- ❑ Other _____
- ❑ Itching/rash
- ❑ Psoriasis
- ❑ Sensitive Skin
- ❑ Skin Cancer
- ❑ Sore won't heal
- ❑ Sweats

GENITO/URINARY

- ❑ Bladder infection
- ❑ Blood/Pus in urine
- ❑ Frequent urination
- ❑ Incontinence
- ❑ Kidney infection
- ❑ Other _____
- ❑ Kidney stones
- ❑ Lowered libido
- ❑ Painful urination
- ❑ Urine stream stops

CARDIOVASCULAR

- ❑ Chest pain
- ❑ Hardening of arteries
- ❑ High cholesterol
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Other _____
- ❑ Angina
- ❑ Pain over heart
- ❑ Poor circulation
- ❑ Heart attack
- ❑ Rapid heart beat
- ❑ Swelling of ankles

GASTROINTESTINAL

- ❑ Acid reflux
- ❑ Belching
- ❑ Black/tarry stool
- ❑ Blood in stool
- ❑ Colitis/IBS
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gas/bloating
- ❑ GERD
- ❑ Other _____
- ❑ Excessive hunger
- ❑ Gall Bladder trouble
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Nausea
- ❑ Pain over stomach
- ❑ Poor appetite
- ❑ Trouble swallowing
- ❑ Vomiting

FOR MEN ONLY

- ❑ BPH
- ❑ Dribbling urine
- ❑ Delayed stream
- ❑ Other _____
- ❑ Erection difficulty
- ❑ Prostate cancer
- ❑ Prostate enlarged

FOR WOMEN ONLY

- ❑ Bleeding between periods
- ❑ Clots with menses
- ❑ Excessive flow
- ❑ Scanty flow
- ❑ Severe menstrual pain
- ❑ Irregular cycle
- ❑ Menopause
- ❑ Miscarriage
- ❑ Breast lumps
- ❑ Breast cancer
- ❑ Endometriosis
- ❑ Fibroids
- ❑ Ovarian cysts
- ❑ PMS
- ❑ PID

Could you be Pregnant? Yes No

Signature

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

Signature: _____ Date: _____

Harmony Community Wellness Center provides high quality acupuncture treatment at affordable rates in a supportive community setting. We practice a style of acupuncture which mostly uses "distal" points in the hands, feet and head to treat problems anywhere in the body – meaning we will probably treat pain in your back by placing tiny needles in your hands. Research in the United States (as well as thousands of years of tradition in Asia) has shown that acupuncture is most effective when it is done frequently and regularly. Once per week is usually the minimum required to make progress on any kind of health problem.

Financial Agreement

Harmony Community Wellness Center makes every attempt to make alternative health care, such as acupuncture and Chinese medicine, available to as many people as possible, at the most affordable rates we can offer.

In respect for our intention to offer high quality health care at affordable prices, we ask for 24 hour notice in advance of an appointment if it is necessary to cancel or reschedule an appointment.

All appointments that are rescheduled or cancelled with less than 24 hour advance notice, and appointments missed without notice, will be charged a $25 fee. If appointments have been purchased in a package, the missed, cancelled or rescheduled appointment will be deducted from the number of remaining appointments in that package.

Community Acupuncture Fees

The first visit is $50. This includes the initial consultation fee.

Additional community acupuncture treatments are $40.

Our primary goal is to make acupuncture affordable, so you may come in often as you need. Usually that means more frequent visits initially, with treatment frequency reducing as your condition improves. Your acupuncturist will guide you.

Our goal is to provide affordable care for the health of our community.

Cancellation Policy

If you need to reschedule or cancel your appointment, please call at least 24 hours in advance. A 50% charge will be due for appointments cancelled or rescheduled less than 24 hours in advance. Exceptions are made for major illness, emergencies, natural disasters and/or death in the family.

_____	_____	_____
Print Name	**Signature of Patient** (or Person Authorized to Consent)	**Date**

www.HCWcenter.com
280 East 3rd Ave, Escondido, CA 92025 | 760-294-1356

Harmony Community WELLNESS CENTER

Patient Name: _____ **Date of Birth:** _____

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.

PATIENT SIGNATURE: _____ **Date**: _____ (Or Patient Representative - Indicate relationship if signing for patient)

OFFICE SIGNATURE: _____ Date: _____

Maki Tanaka Nielsen, L.Ac., Dipl. Ac.
Lars Nielsen, L.Ac. Dipl. OM
Harmony Acupuncture and Wellness Center, Inc.
DBA - Harmony Community Wellness Center

Harmony Community WELLNESS CENTER

Patient Name: _____ **Date of Birth:** _____

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 tor 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: _____ **Date:** _____ (Or Patient Representative - Indicate relationship if signing for patient)

OFFICE SIGNATURE: _____ Date: _____

Harmony Community
WELLNESS CENTER

Consent for Purposes of Treatment, Payment, and Health Care Operation

I consent to the use or disclosure of my identifiable health information by Harmony Community Wellness Center (hereafter noted as HCWC) for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at *Harmony Community Wellness Center* may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. *HCWC* is not required to agree to the restrictions that I may request. However, if HCWC agrees to a restriction that I request, the restriction is binding upon *HCWC*.

I have the right to revoke this consent, in writing, at any time except to the extent that *Harmony Community Wellness Center* has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review HCWC's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Harmony Community Wellness Center employees. The Notice of Privacy Practices is also provided at the front desk and on the organization's web site at www.HCWcenter.com. This Notice of Privacy Practices also describes my rights and the duties of my practitioners at Harmony Community Wellness Center with respect to my identifiable health information.

Harmony Community Wellness Center reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

_____ _____

Signature of Patient or Authorized Representative **Date**

_____

Printed Name and Relationship