Acupuncture & Holistic Pain Clinic

(919) 322-4095 | ahpclinic@gmail.com
184 Wind Chime Ct Ste 203, Raleigh, NC 27615

Patient Confidential Information:

Name: _____ Date: _____
(first) (middle) (last)

Age: _____ DOB: _____ Gender: _____ Marital Status: _____
(mm/dd/yyyy)

Address:_____ City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Occupation: _____

Primary Care Physician: _____

Referral/Source: _____

Emergency Contact: _____ Phone Number: _____

What do you expect from acupuncture/herbal medicine?: _____

_____

List the main conditions for which you would like help: _____

_____

How long have you had this issue? Cause of issue?: _____

_____

Have you received a diagnosis for this issue? If so, what is it?: _____

_____

Any previous treatment for this issue?: _____

How effective was it?: _____

List any current medications: _____

List any allergies: _____

Signature: _____ Date: _____

Permission to treat a minor:

As legal guardian of the named child, _____ , I give permission for him/her to receive treatment and be examined by Dr. Choi L.Ac.

_____
Parent or Legal Guardian Signature

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Personal Medical History:

Significant Illnesses:

____ Cancer	____ Seizures	____ Diabetes	____ Asthma	____ Stroke
____ Hepatitis	____ Heart Disease	____ Thyroid Disease	____ Herpes	____ Mental Illness
____ HIV (AIDS)	____ Weight Problem	____ Venereal Disease	_ _ High Blood Pressure	_ _ Other:
_ _ Allergies	_ _ Tuberculosis	____ Addictive Disorders	_ _ Rheumatic Fever	_____

Please mark any symptoms you have experienced in the last **3 months.**

General:

____ Poor Appetite	____ Localized Weakness	____ Odd tastes or smells	____ Sweat easily	____ Headaches
____ Fevers	____ Insomnia	____ Bleeding	____ Change in appetite	____ Sudden Energy Drop
____ Fatigue	____ Strong thirst	____ Weight loss	____ Night sweats	____ Hearing loss
____ Tremors	____ Poor balance	____ Weight gain	____ Depression	____ Bruising easily
____ Cravings	____ Chills	____ Joint pain	____ Emotional changes	

Skin and Hair:

____ Rashes	____ Itching	____ Change in skin texture	____ Ulcers	____ Hives
____ Eczema	____ Hair loss	____ Dandruff	____ Acne	____ Psoriasis
____ Recent moles	____ Change in hair texture			

ENT and Head and Eyes (HEENT):

____ Dizziness	____ Eye Pain	____ Ear aches	____ Mirgraine	____ Recurrent Sore Throat	____ Color Blindness
____ Ringing in ears	____ Glasses	____ Glaucoma	____ Eye Strain		____ Jaw Click
____ Gum problems	____ Sinus Problem	____ Poor Vision	____ Teeth Grinding	____ Sores on Lips	____ Poor Hearing
____ Night blindness	____ Headaches	____ Cataracts	____ Floaters	____ Mouth ulcers	____ Nose Bleeds
____ Facial pain	____ Blurred vision	____ Concussion	____ Seeing spots	____ Toothache	

Respiratory:

____ Cough	____ Bronchitis	____ Asthma	____ Easily winded	____ Coughing Blood
____ Wheezing	____ Phlegm	____ Shortness of Breath	____ Painful Breathing	

Cardiovascular:

____ Blood Clots	____ Fainting	____ Cold hands or feet	____ Low Blood Pressure	____ Irregular Heartbeat
____ Phlebitis	____ Dizziness	____ Swelling of hands	____ Shortness of Breath	____ Difficult Breathing
____ Chest pain	____ Swelling of hands			

Gastrointestinal:

____ Nausea	____ Bloating	____ Blood in stool	____ Abdominal Pain	____ Indigestion
_ _ Belching	____ Constipation	____ Black stool	____ Vomiting	____ Parasites
____ Diarrhea	____ Hemorrhoids	____ Bad Breath	____ Gastric ulcers	____ Intestinal Gas

Genital/Urinary:

____ Painful urination	____ Urgent Urination	____ Scanty Urination	____ Frequent urination	____ Kidney stones
____ Blood in Urine	____ Impotence	____ Unable to hold urine	____ Genital Sores	____ Discolored urine

Gynecology and Pregnancy:

____ Irregular period	____ PMS	____ Breast lumps	____ Age of 1st period _____	____ # of births _____
____ Clots	____ Painful Periods	____ Vaginal discharge	____ Date of last period _____	____ # of miscarriages _____
____ Light Flow	____ Difficult births	____ Vaginal sores	____ Last PAP _____	____ # of abortions _____
____ Heavy Flow	____ Fertility problems	____ Duration of flow _____	____ # of Pregnancies _____	____ # of premature births ___

Neuro-Psychological:

____ Seizures	____ Disorienation	____ Poor memory	____ Depression	____ Loss of balance
____ Dizziness	____ Areas of numbness	____ Migraines	____ Anxiety	____ Mood swings
____ Stress	____ Lack of coordination	____ Concussion	____ Easily angered	____ Irritability

Muscular and Skeletal:

____ Neck Pain	____ Back pain	____ Joint pain	____ Muscle spasms	____ Injuries
____ Scoliosis	____ Shoulder pain	____ Knee Pain	____ Muscle cramping	____ Foot/Ankle pain
____ Hip pain	____ Arthritis	____ Muscle weakness	____ Muscle soreness	____ Hand/wrist pain
____ Recent sprains	____ Weak joints			

Have you ever received psychiatric treatments? _____

Have you considered or attempted suicide? _____

Do you have any nervous habits?_____

Do you have any other issues you would like Dr. Choi to be aware of? _____

Is there any possibility that you are pregnant? _____

Do you have any biomedical devices, such as artificial joints or cardiac pacemaker? _____

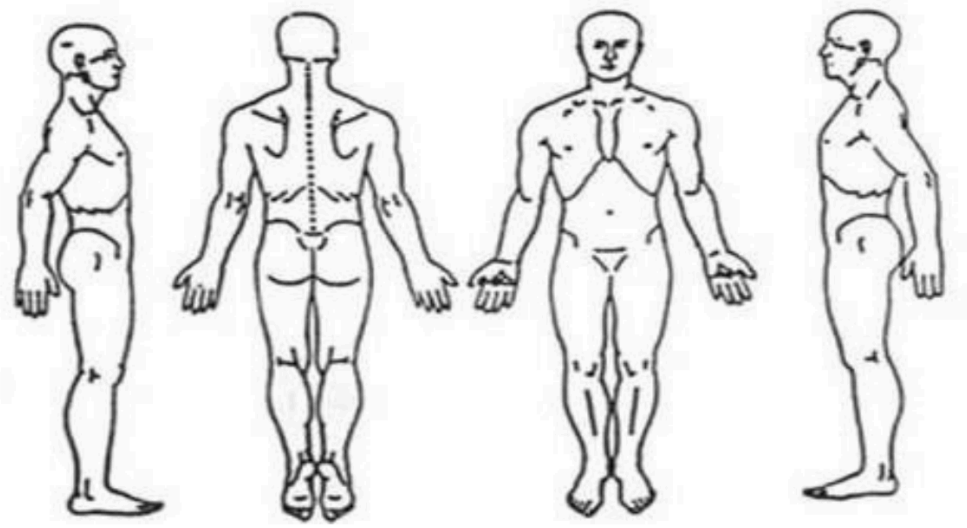
Describe any use of tobacco, alcohol, caffeine, and recreational drugs? _____

Pain Diagram:

How long have you had pain: _____ years _____ months _____ weeks

On the diagram below, please indicate where you are now experiencing pain or other symptoms:

A = Ache	P = Pins and Needles	B = Burning
S = Stabbing	N = Numbness	O = Other



Acupuncture & Holistic Pain Clinic

Informed Consent to Acupuncture Treatment:

- Treatments shall be given in surroundings that provide privacy and confidentiality.
- Every acupuncture office shall be maintained in a clean and sanitary condition at all times and shall have a readily accessible bathroom facility.
- OSHA Standards for blood borne pathogens shall be met.

I hereby request and consent to the performance of acupuncture and other procedures within the scope of the practice of acupuncture on me (or the patient named below for whom I am legally responsible) by Dr. Choi L.Ac. and/ or other licensed acupuncturists who now or in the near future treat me while employed by, working or associated with or serving as back-up for Dr. Choi, L.Ac. including those working at his office or any other office or clinic, whether signatories to this form or not.

I have had the opportunity to discuss with the acupuncturist the nature and purpose of this treatment.

I understand and have been informed that as in the practice of medicine, in the practice of acupuncture, there are some risks to treatment, including, but not limited to: nausea, a punctured lung, and infection.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to treatment with Dr. Choi, L.Ac. 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's Name: _____ Date: _____
(print)

Patient's Signature: _____

To be completed by the patient's representative if the patient is a minor or physically, or legally incapacitated.

Patient's Representative: _____ Date: _____
(print)

Relationship to Patient: _____
(print)

Arbitration Agreement:

Agreement to Arbitrate: It is understood that any dispute as to the 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 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.

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 relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) 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 office whether signatories 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 health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss or consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

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 rate 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 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 judgment for future damages conformed to periodic payments, shall apply to disputes within this ArbitrationAgreement. The parties further agree that the CommercialArbitration Rules o f theAmerican ArbitrationAssociation shall govern any arbitration conducted pursuant to this Arbitration Agreement.

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 the reasonable diligence.

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.

Retroactive Effect: If the 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 thisArbitrationAgreement 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 practice decided by neutral arbitration and you are giving up your right to a jury or court trial. See first paragraph of this contract.

Patient's Signature: _____ Date: _____

Relationship to Patient: _____
(print)

Office Signature: _____ Date: _____

Acupuncture & Holistic Pain Clinic

Cancellation Policy:

Dear Patient,

Thank you for choosing Acupuncture & Holistic Pain Clinic as an Oriental Medicine provider. We strive to render excellent medical care to you, your family, and all of our patients. In order to be consistent with this philosophy, Acupuncture & Holistic Pain Clinic uses an appointment system that sets aside ample time for a patient dependent on the patient's current needs.

If you do not show up for your appointment, or notify us of your inability to keep your appointment by phone at least 24 hours in advance, the time that has been allotted for your visit cannot be used to treat another patient and is time lost to our office.

Our policy is as follows:

1. 1. We request that you please give our office a 24-hour notice in the event that you need to reschedule your appointment. This will make the appointment time available to someone else. Our scheduling number is 919-322-4095.
2. 2. If you miss an appointment and do not contact us with at least 24 hours prior notice, we will consider this to be a missed appointment and a regular session fee will be assessed to you.
3. 3. If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length.

The following credit card will be held on file and ONLY be charged in the event a cancellation fee is due.

Credit Card Number: _____ Exp. Date: _____ CVV: _____

I hereby authorize Acupuncture & Holistic Pain Clinic to charge my credit card in the event that I owe a cancellation fee.

Patient's Name: _____ Date: _____
(print)

Patient's Signature: _____

To be completed by the patient's representative if the patient is a minor or physically, or legally incapacitated.

Patient's Representative: _____ Date: _____
(print)

Relationship to Patient: _____

I acknowledge that I have received a copy of this Cancellation Policy: _____
(initial upon receipt of copy)