



Acupuncture & Holistic Pain Clinic

(919) 322-4095 | ahpcclinic@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



Acupuncture & Holistic Pain Clinic

Personal Medical History:

Significant Illnesses:

- | | | | | |
|-------------------------------------|---|--|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Herpes | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> HIV (AIDS) | <input type="checkbox"/> Weight Problem | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Addictive Disorders | <input type="checkbox"/> Rheumatic Fever | _____ |

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

General:

- | | | | | |
|--|---|---|---|---|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Odd tastes or smells | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Sudden Energy Drop |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Poor balance | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Depression | <input type="checkbox"/> Bruising easily |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Chills | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Emotional changes | |

Skin and Hair:

- | | | | | |
|---------------------------------------|---|---|---------------------------------|------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Itching | <input type="checkbox"/> Change in skin texture | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Acne | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Recent moles | <input type="checkbox"/> Change in hair texture | | | |

ENT and Head and Eyes (HEENT):

- | | | | | | |
|--|---|--------------------------------------|---|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Ear aches | <input type="checkbox"/> Migraine | <input type="checkbox"/> Recurrent Sore | <input type="checkbox"/> Color Blindness |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Glasses | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Throat | <input type="checkbox"/> Jaw Click |
| <input type="checkbox"/> Gum problems | <input type="checkbox"/> Sinus Problem | <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Teeth Grinding | <input type="checkbox"/> Sores on Lips | <input type="checkbox"/> Poor Hearing |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Floaters | <input type="checkbox"/> Mouth ulcers | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Facial pain | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Concussion | <input type="checkbox"/> Seeing spots | <input type="checkbox"/> Toothache | |

Respiratory:

- | | | | | |
|-----------------------------------|-------------------------------------|--|--|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Easily winded | <input type="checkbox"/> Coughing Blood |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Phlegm | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Painful Breathing | |

Cardiovascular:

- | | | | | |
|--------------------------------------|--|---|--|--|
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Swelling of hands | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Difficult Breathing |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Swelling of hands | | | |

Gastrointestinal:

- | | | | | |
|-----------------------------------|---------------------------------------|---|---|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Bloating | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Constipation | <input type="checkbox"/> Black stool | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Gastric ulcers | <input type="checkbox"/> Intestinal Gas |

Genital/Urinary:

- | | | | | |
|--|---|---|---|---|
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Urgent Urination | <input type="checkbox"/> Scanty Urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Impotence | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Genital Sores | <input type="checkbox"/> Discolored urine |

Gynecology and Pregnancy:

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> Irregular period | <input type="checkbox"/> PMS | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Age of 1st period _____ | <input type="checkbox"/> # of births _____ |
| <input type="checkbox"/> Clots | <input type="checkbox"/> Painful Periods | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Date of last period _____ | <input type="checkbox"/> # of miscarriages _____ |
| <input type="checkbox"/> Light Flow | <input type="checkbox"/> Difficult births | <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Last PAP _____ | <input type="checkbox"/> # of abortions _____ |
| <input type="checkbox"/> Heavy Flow | <input type="checkbox"/> Fertility problems | <input type="checkbox"/> Duration of flow _____ | <input type="checkbox"/> # of Pregnancies _____ | <input type="checkbox"/> # of premature births _____ |

Neuro-Psychological:

- | | | | | |
|------------------------------------|---|--------------------------------------|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Disorientation | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Migraines | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Concussion | <input type="checkbox"/> Easily angered | <input type="checkbox"/> Irritability |

Muscular and Skeletal:

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Back pain | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Injuries |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Muscle cramping | <input type="checkbox"/> Foot/Ankle pain |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Muscle soreness | <input type="checkbox"/> Hand/wrist pain |
| <input type="checkbox"/> Recent sprains | <input type="checkbox"/> 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? _____

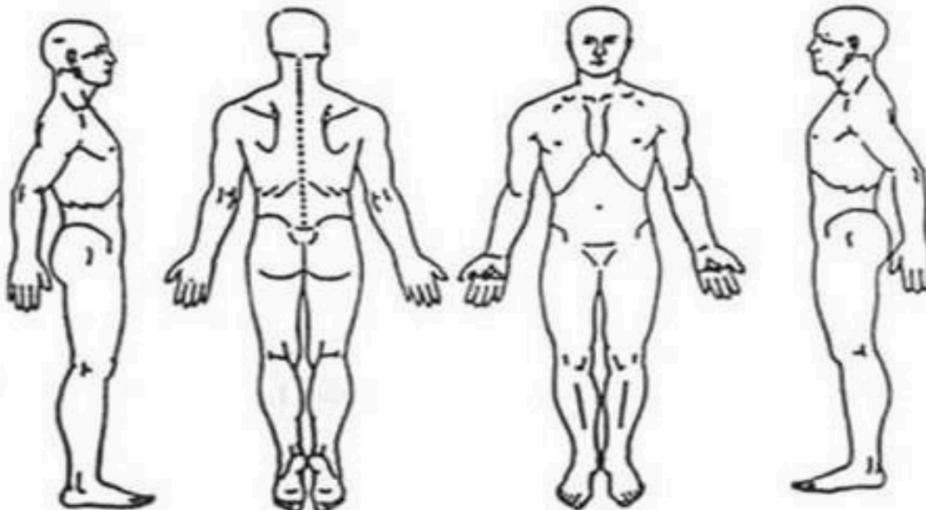
Describe any use of tobacco, alcohol, caffeine, and recreational drugs? _____

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)



Acupuncture & Holistic Pain Clinic

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 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.

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 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 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)