Acupuncture & Holistic Pain Clinic

184 Wind Chime Ct Ste 203, Raleigh, NC 27615
919-322-4095 Email: ahpclinic@gmail.com

Patient Confidential Information

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

Age _____ DOB _____ Gender _____ Marital Status _____
mm/dd/year

Address _____ City _____ State ____ Zip _____

Telephone (H) _____ (W) _____ (C) _____

Email address_____ Occupation _____

Primary Care Physician_____

Who may we thank for your referral? _____

What do you expect from acupuncture/herbal medicine?_____

_____

Emergency Contact _____Telephone _____

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

_____

How long have you had this issue? _____Do you know it's cause? _____

Have you been given a diagnosis for this problem? If so, what is it? _____

_____

What kinds of treatment have you tried for the issue? _____

_____

How effective was it? _____

List your current medications _____

List your 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

Personal Medical History

Significant Illnesses

___Cancer
___Hepatitis
___HIV (AIDS)
___Allergies
___Asthma
___Seizures
___Heart Disease
___Weight Problem
___Tuberculosis
___Herpes
___Diabetes
___Thyroid Disease
___Venereal Disease
___Addictive Disorders
___High Blood Pressure
___Rheumatic Fever
___Stroke
___Mental Illness
___Other:
_____

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

General

___Poor Appetite
___Fevers
___Fatigue
___Tremors
___Cravings
___Headaches
___Localized Weakness
___Insomnia
___Strong thirst
___Poor balance
___Chills
___Sudden Energy Drop
___Odd tastes or smells
___Bleeding
___Weight loss
___Weight gain
___Joint pain
___Hearing loss
___Sweat easily
___Change in appetite
___Night sweats
___Depression
___Emotional changes
___Bruising easily

Skin and Hair

___Rashes
___Eczema
___Recent moles
___Itching
___Hair loss
___Change in hair texture
___Change in skin texture
___Dandruff
___Hives
___Ulcers
___Acne
___Psoriasis

ENT + Head and Eyes (HEENT)

___Dizziness
___Ringing in ears
___Gum problems
___Night blindness
___Facial pain
___Color blindness
___Eye pain
___Glasses
___Sinus problems
___Headaches
___Blurred vision
___Jaw click
___Earaches
___Glaucoma
___Poor vision
___Cataracts
___Concussion
___Poor hearing
___Migraine
___Eye strain
___teeth grinding
___Floaters
___Seeing spots
___Nose bleeds
___Recurrent sore throat
___Sores on lips
___Mouth ulcers
___Toothache

Respiratory

___Cough
___Wheezing
___Coughing blood
___Bronchitis
___Phlegm
___Asthma
___Shortness of breath
___Easily winded
___Painful breathing

Cardiovascular

___Blood clots
___Phlebitis
___Chest pain
___Fainting
___Dizziness
___Swelling of feet
___Cold hands or feet
___Swelling of hands
___Irregular heartbeat
___Low blood pressure
___Shortness of breath
___Difficult breathing

Gastrointestinal

___Nausea
___Belching
___Diarrhea
___Indigestion
___Bloating
___Constipation
___Hemorrhoids
___Parasites
___Blood in stools
___Black stools
___Bad breath
___Intestinal gas
___Abdominal pain
___Vomiting
___Gastric ulcers

Genito/Urinary

___Painful urination
___Blood in urine
___Genital sores
___Urgent urination
___Impotence
___Kidney stones
___Scanty urination
___Unable to hold urine
___Discolored urine
___Frequent urination
___Frequent night urination

Gynecology and Pregnancy (females only)

___Irregular period
___Clots
___Light flow
___Heavy flow
___PMS
___Duration of flow _____
___Painful periods
___Age of 1st menses_____
___Date of last menses_____
___Last PAP _____
___# of pregnancies _____
___# of births _____
___# of miscarriages _____
___# of abortions _____
___# of premature births___
___Difficult births
___Fertility problems
___Breast lumps
___Vaginal discharge
___Vaginal sores

Neuro-Psychological

___Seizures	___Areas of numbness	___Concussion	___Loss of balance
___Dizziness	___Lack of coordination	___Depression	___Mood swings
___Stress	___Poor memory	___Anxiety	___Irritability
___Disorientation	___Migraines	___Easily angered	___Headache

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? _____

Muscular and Skeletal

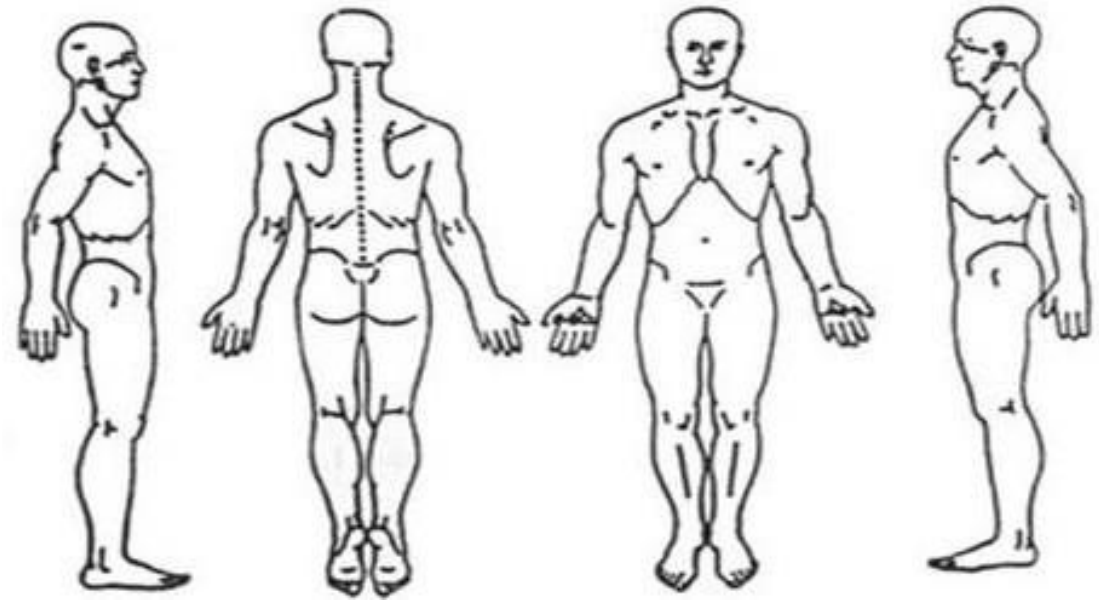
___Neck pain	___Back pain	___Joint pain	___Muscle spasms
___Scoliosis	___Shoulder pain	___Knee pain	___Muscle cramping
___Hip pain	___Arthritis	___Muscle weakness	___Muscle soreness
___Recent sprains	___Weak joints	___Injuries	___Foot / Ankle pain
			___Hand/wrist pain

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 & 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 the his office or any other office or clinic, whether signatories to this form or not.

I have had 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 patient's representative if 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 ad 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 o f 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. 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. 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. 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 will ONLY be charged in the event a cancellation fee is due.

Credit Card Number _____ Exp Date _____CV code _____

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 patient's representative if 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) _____ _____