Personal Information

Name _____ Date _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Email _____

Work Phone _____ Occupation _____

Emergency Contact: _____ Phone _____

Who should we thank for referring you to this office? _____

Sex: ❑ Male ❑ Female **Marital Status:** ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Have you received acupuncture therapy before? ❑ Yes ❑ No

When? _____ With Whom? _____

Please indicate any significant illnesses you or a blood relative (Grandparent, parent, sibling) have had:

Illness	You	Your Relative	Approx. Date	Illness	You	Your Relative	Approx. Date
Cancer	❑	❑	_____	Diabetes	❑	❑	_____
Hepatitus	❑	❑	_____	Heart Disease	❑	❑	_____
High Blood Pressure	❑	❑	_____	Seizures	❑	❑	_____
Rheumatic Fever	❑	❑	_____	Emotional Disorders	❑	❑	_____
Infectious Diseases	❑	❑	_____	Tuberculosis	❑	❑	_____
Sexually							

Trans. Diseases: ❑ Gonorrhea ❑ Syphilis ❑ AIDS ❑ HPV ❑ Chlamydia ❑ Herpes **DATE:** _____

List any medications and supplements you are currently taking:

Medicine	Dosage	Reason	How Long	Prescribed By	Date of Last Checkup

Check the box if any of the following statements are true: ❑ I have known allergies. ❑ I have a pacemaker ❑ I am taking Coumadin/warfarin. ❑ I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs)

Please indicate the use and frequency of the following:

Substance	Yes	No	How Much	Substance	Yes	No	How Much	Substance	Yes	No	How Much
Coffee/Black tea	❑	❑	_____	Tobacco	❑	❑	_____	Water Intake	❑	❑	_____
Non-Medical Drugs	❑	❑	_____	Alcohol	❑	❑	_____	Soda Pop	❑	❑	_____

What are the main health problems for which you are seeking treatment?

What other forms of treatment have you sought?

List any other health problems you now have.

List any allergies, food sensitivities, or food craving that you have.

List any accidents, surgeries, or hospitalizations (include date).

Lab Results (please include copies).

Clinical Notes

(Practioner's USe)

HPI:

☐ Onset ☐ Location ☐ Duration ☐ Characteristics
☐ Aggravate/Allev. ☐ Related Factors ☐ Treatment

How do you FEEL about the following areas of your life?

Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad
Signif. Other	☐	☐	☐	☐	☐
Family	☐	☐	☐	☐	☐
Diet	☐	☐	☐	☐	☐
Sex	☐	☐	☐	☐	☐
Self	☐	☐	☐	☐	☐
Work	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐
Spirituality	☐	☐	☐	☐	☐

Your Comments

For Women

Age of 1st period (menarche) _____ Are you pregnant? ☐ Yes ☐ No Number of pregancies _____

Age of last period (menopause) _____ # of live births _____ # of abortions _____ # of miscarriages _____

Number of days between periods _____ Date of last: Gynecologic Exam _____ Pap Smear _____

Number of days of flow _____ Mammogram _____ Bone Density Scan _____

Color of flow _____ Results _____

Clots? ☐ Yes ☐ No Color _____

Average number of pads you use per day: 1st day _____ 2nd day _____ 3rd day _____ 4th day _____ + days _____

Have you been diagnosed with: ☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ PID **Other** _____

Location of pain: ☐ Lower abdomen ☐ Lower back ☐ Thighs ☐ Other _____

Nature of Pain (Please indicate before, during or after menses)

Cramping _____ Cramping _____

Burning _____ Burning _____

Dull _____ Dull _____

Consistent _____ Consistent _____

Bearing down sensation _____

Other symptoms related to menses:

☐ Discharge ☐ Vaginal dryness ☐ Headache

☐ Nausea ☐ Constipation ☐ Diarrhea

☐ Swollen breasts ☐ Mood swings ☐ Ravenous appetite

☐ Poor appetite ☐ Hot flashes ☐ Night sweats

☐ Increased libido ☐ Decreased libido ☐ Insomnia

For Men

Date of last prostate checkup _____ PSA results _____ Manual prostate exam results _____

Lab results _____

Frequency of urination: daytime _____ nighttime _____ Color of urine: ☐ clear ☐ murky Odor: _____

Symptoms related to prostate:

☐ Prostate problems ☐ Delayed stream ☐ Dribbling ☐ Incontinence ☐ Retention of urine

☐ Rectal dysfunction ☐ Increased libido ☐ Decreased libido ☐ Premature ejaculation ☐ Impotence

☐ Back pain ☐ Groin pain ☐ Testicular pain Other _____

Symptom Survey (For Everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
no mark ( ) = never experience **check mark** (✓) = sometimes experience **plus sign** (+) = frequently experience

_____lack of appetite
_____excessive appetite
_____loose stool or diarrhea
_____digestive problems, indigestion
_____vomiting
_____belching, burping
_____heartburn/reflux
_____feeling the retention of food in the stomach
_____tendency to become obsessive in work, relationships, etc.
_____insomnia, difficulty sleeping
_____heart palpatations
_____cold hands and feet
_____nightmares
_____mentally restless
_____laughing for no apparent reason
_____angina pains
_____abdominal pain
_____chest pain
_____sciatic pain
_____headaches
_____pain or coldness in the genital area
_____cough
_____shortness of breath
_____decreased sense of smell
_____nasal problems
_____skin problems
_____feeling of claustrophobia
_____bronchitis
_____colitis or diverticulitis
_____constipation
_____hemorrhoids
_____recent use of antibiotics
_____eye problems
_____jaundice (yellowish eyes or skin)
_____difficulty digesting oily foods
_____gall stones
_____light colored stool
_____soft or brittle nails
_____easily angered or agitated
_____difficulty in making plans or decisions
_____spasms or twitching of muscles
_____low back pain
_____knee problems
_____hearing impairment
_____ear ringing
_____kidney stones
_____decreased sex drive
_____hair loss
_____urinary problems
_____fatigue
_____edema
_____blood in stool
_____black tarry stool
_____easily bruised
_____difficult to stop bleeding
_____asthma
_____tendency to catch colds
_____intolerance to weather changes
_____allergies
_____hay fever
_____dizziness
_____tendency to faint easily
_____high cholesterol levels
_____sudden weight loss

Patient _____ **Age:**____ **Sex:**____ **Plan#:**____ **TX#:**____ **Time:**____ **Date:**_____

S. Response to last tx: _____

CC: _____ Severity (1-10) _____ 10 2nd SX: (1-10) _____

History of CC: (OLDCAARTS) _____

NewSx: _____

S: Ten Questions/ROS

Energy Level: _____

Sleep: _____

Temp/sweat: _____

Appetite/thirst: _____

Digestion: _____

Elimination: _____

HEENT: _____

P: _____ Mens: _____

Emotional: _____

Pain: _____

Other: _____

O: Physical Exam of CC: *(EENT, Auscultation Ht/Lu, Abdominal Exam, Palpation & ROM, Ortho/Neuro)*

_____

_____

_____

Pulse Rate:

Supine BP: ____/____L/R

Sit / Stand: ____/____L/R

Temp: Ht: Wt:

Shen/Face/Voice/Odor:

Pulse: Speed, depth, strength, quality

	Left	Rate
Cun	_____	_____
Guan	_____	_____
Chi	_____	_____

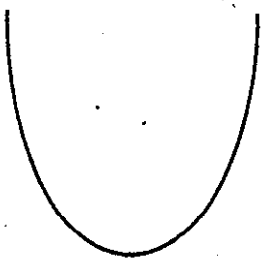
Tongue

Body: Shape, size, motility

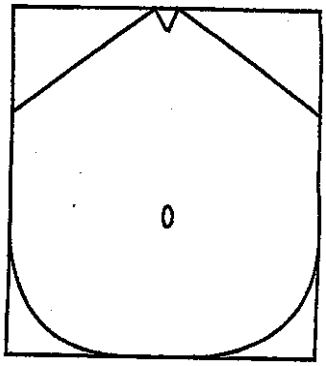
Body: Color, quality, moisture

Coat: Quality, thickness, color, moisture

Tongue Illustration



Hara Illustration



Etiology:

Present Diagnosis:

Treatment Principle:

: Treatment: *(Circle supplement, drain, neutral. Circle Moxa or Estim. Check left, right or bilateral)*

Pt(s): _____ S D N *M Estim* _L _R _Bilat
Fx: _____
Pt(s): _____ S D N *M Estim* _L _R _Bilat
Fx: _____
Pt(s): _____ S D N *M Estim* _L _R _Bilat
Fx: _____
Pt(s): _____ S D N *M Estim* _L _R _Bilat
Fx: _____
Pt(s): _____ S D N *M Estim* _L _R _Bilat
Fx: _____

Pt(s): _____ S D N *M Estim* _L _R _Bilat
Fx: _____
Pt(s): _____ S D N *M Estim* _L _R _Bilat
Fx: _____
Pt(s): _____ S D N *M Estim* _L _R _Bilat
Fx: _____

Tot # needle:

Retain/min:

Auricular: __needle __tac __seed
Pts: _____

Bleeding: _____
Estim type used: __micro __traditional
Machine: _____
Setting: _____
Hot Pack: _____

__Gua Sha __Cupping _____
__Massage __Tui Na _____
__Moxa w/needle - Type: _____ Pts: _____
__Shoni Shin __Other: _____ Pts: _____

Name of Base Formula: _____
Patent Name or Ref #: _____
Special Instructions: _____
# of Packs: _____ Refills allowed? __No __Yes How many? _____

__New prescription __Refill
__Modification of previous prescription

Herb	Dose	Herb	Dose	Herb	Dose	Herb	Dose

Adjunctive tx: __Lifestyle __Diet __Exercise __Other

Unanswered? Or thoughts for next visit: _____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including 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, as to whether this agreement is unconscionable, and any 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, preceptors, or 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. This agreement is intended to create an open book account unless and until revoked.

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 of 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.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

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, Tiu-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. 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 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 **X** (Date)

(Or Patient Representative) (indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

HIPAA PRIVACY NOTICE
EFFECTIVE APRIL 14TH, 2003

This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information.

This office has always recognized the importance of privacy; this new federal law formalizes practices that have been followed routinely.

Background: In 1996, Congress recognized the need for national patient privacy standards and, as part of the Health Insurance Portability and Accountability Act, abbreviated HIPAA, ordered that a set of rules be established to control how health information is used and disclosed, as maintained by doctors, hospitals, and health plans. Health information is considered sensitive and personal, and the law establishes consumer protection and limits the sharing of such information, as so similar protections already enacted for back accounts, credit cards, and even video rentals.

- By the law, consent is not required to discuss your medical treatment with your other doctors or health care providers. This allows for prescriptions to be called in to your pharmacy and for scheduling of surgery in a hospital.
- Additionally, none is needed in the course of carrying out health care operations, such as assessment, or in communication with your insurance carrier for payment related issues, or for incidental uses such as announcing a name in a waiting room or the use of sign-in sheets.
- However, this office has always gone one step further in protecting you and does not believe in releasing specific information about you to any business or government entity without your written consent.
- Specific authorization is required to disclose protected information in a non-routine circumstance such as to your employer for use in marketing a product for you.
- Medical information about you may be related for research and public health uses, as long as you are not individually identified.
- You are guaranteed access to review your medical records and you may amend the record if you believe it to be incomplete or inaccurate.
- You have the right when and to whom your information was related.
- You may suggest additional restrictions with regard to certain uses and disclosures as you wish.
- Portions of this notice may be modified as long as you are notified.
- Should you believe that your privacy rights have been compromised you may report the violation, without penalty to you to this office, or to the Secretary of Health.
- The law requires that you acknowledge receipt of this notice. This has been included on the signature release on your registration form.

Patient's Signature and Date: X _____

Patient Advisory to Consult a Physician

In compliance with New York State law, the patient

_____ has been advised by

_____, L.Ac to consult a physician for the condition that s/he is seeking treatment for:

Patient Signature X _____

Date _____

Licensed Acupuncturist Signature _____

Date _____