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 or 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 tea consumed according to the instructions provided orally and in writing. The herbs may have 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 my 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 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 becoming 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 my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff my review my patient records and lab reports, but all my records will be kept confidential and will not be released without my 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** (Or Patient Representative)

(Indicate relationship if signing for patient)

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical service 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) or the patient in relation to all claims, including loss of consortium. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who no 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 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 poor additional party 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 for 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 procedure 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 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 JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE **X**

(Indicate relationship if signing for patient)

OFFICE SIGNATURE **X**

Patient Confidential Information

Name: _____
First Middle Last

Address: _____
Street

_____
City State Zip

Primary Phone: _____ Alternate Phone: _____
Select One: Mobile / Home / Work Mobile / Home / Work

Please provide an E-mail address at which you would like to receive appointment reminders:
E-mail: _____

~~SSN:~~ _____ - _____ - _____

Age: _____ Date of Birth: _____ Sex: M F Marital Status: S M D W

Place of Birth: _____ Occupation: _____ Employer: _____

If you would like us to bill your insurance company for services rendered, please furnish your insurance information at the front desk prior to treatment. We do not guarantee insurance benefits. Regardless of insurance coverage, all services provided are the financial responsibility of the patient or the parent(s)/guardian(s) of the patient.

Whom may we thank for referring you to our office? _____

In case of emergency, call: _____
Name Relation

Primary phone: _____ Alternate Phone _____

CANCELLATION POLICY:
Out of respect for the practitioner's time and in order to maximize availability to patients, a minimum of 24 hours notice for cancellations is required. Not providing 24 hours notice, not showing, or being more than 20 minutes late for appointment results in a charge of the standard fee to your account. If your appointment slot is filled after you cancel, this fee is waived. Compliance with this policy enables better service to you and other patients.
Thank you for your understanding.

_____ _____
Patient Signature Date

Medical History Questionnaire

Please complete the following as completely and accurately as possible.

Name: _____ Date: _____

Present Illness/Injury:

Please list your major symptoms that concern you in order of importance

	Symptom	When did this condition begin?	What treatment have you received already?
1			
2			
3			
4			
5			

Medical History:

What surgeries have you had? When did you have them?

What other serious injuries or illnesses have you had? When?

What allergies, if any do you have?

What medications have you taken within the last 3 months (include dosages)?

What supplements are you taking (include dosages)?

Have any of your blood relatives had any of the following?

- ☐ Stroke
- ☐ Cancer
- ☐ Heart Disease
- ☐ Tuberculosis
- ☐ Seizures
- ☐ Bleeding disorder
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Thyroid disorder
- ☐ Allergies

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Check the symptoms that pertain to you:

- ☐ Vomiting
- ☐ Diarrhea alternating with constipation
- ☐ Tight feeling in the chest
- ☐ Bitter taste in the mouth
- ☐ Blood shot/dry eyes
- ☐ Anger easily
- ☐ Skin rashes
- ☐ Headache
- ☐ Numbness of hands and feet
- ☐ Muscles spasms, twitching, cramping
- ☐ Seizures/convulsions
- ☐ Sore, cold or weak knees
- ☐ Low back pain
- ☐ Frequent urination
- ☐ Get up more than once per night to urinate
- ☐ Lack of bladder control
- ☐ Memory problems
- ☐ Hair loss
- ☐ Ringing in ears

Urine is:

- ☐ Pale yellow
- ☐ Clear
- ☐ Dark yellow
- ☐ Reddish
- ☐ Cloudy
- ☐ Scanty
- ☐ Has odor
- ☐ Burning
- ☐ Painful
- ☐ Difficult
- ☐ Urgent

Libido (sex drive) is :

- ☐ Low
- ☐ Moderate
- ☐ High

Indicate if you currently have or have had any of the following:

- ☐ Cold sores
- ☐ Genital herpes
- ☐ Epstein Barr virus (EBV)
- ☐ Fibromyalgia
- ☐ Heart disease
- ☐ Rheumatic fever
- ☐ High blood pressure
- ☐ Stroke
- ☐ Epilepsy or convulsions
- ☐ Kidney disease
- ☐ Urinary bladder problems or infections
- ☐ Diabetes mellitus
- ☐ Cancer
- ☐ Respiratory problems
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Warts
- ☐ Peptic Ulcer
- ☐ Pancreatitis
- ☐ Anemia or other blood disorder
- ☐ Bleeding disorder
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Hernia
- ☐ Thyroid disorder
- ☐ Hemorrhoids
- ☐ Sexually transmitted diseases
- ☐ Disorder of the genitals
- ☐ Gynecological disorder
- ☐ Congenital abnormalities
- ☐ Skin diseases
- ☐ Cardia pacemaker
- ☐ Surgical implants
- ☐ Change in bowel or bladder habits
- ☐ Sores that will not heal
- ☐ Unusual bleeding or discharge
- ☐ Indigestion
- ☐ Colitis
- ☐ Crohn's disease
- ☐ Irritable bowel syndrome/disease
- ☐ Gallstones
- ☐ Lupus Erythematosus
- ☐ Difficulty swallowing
- ☐ Obvious change in a wart or mole
- ☐ Chronic Cough
- ☐ Hoarseness
- ☐ History of smoking
- ☐ History of smokeless tobacco use
- ☐ History of drinking alcohol
- ☐ History of recreational drug use
- ☐ HIV/AIDS

Name: _____

Women: Menstrual History

Age of your first period: _____

Length of flow (days): _____

Length of entire menstrual cycle, from day 1 of one period to day 1 of next period: _____

Date of your last period: _____

Any abnormal vaginal discharge?: yes no

Do you believe you are pregnant or that it may be possible? yes no

Number of previous pregnancies: _____ Number of live births: _____

Date of last gynecological checkup: _____

Are you taking birth control pills/patch? yes no

Have you taken birth control pills in the past? yes no

If yes, dates of use:

Do you have a history of any of the following?

- ☐ Menstrual cramps
- ☐ Menstrual blood clots
- ☐ Excessive bleeding
- ☐ PMS
- ☐ Breast swelling/tenderness
- ☐ Water gain
- ☐ Abnormal Pap smear
- ☐ Irregular cycle
- ☐ History of hormone therapy
- ☐ Breast cysts
- ☐ Ovarian cysts
- ☐ Endometriosis
- ☐ Pregnancy
- ☐ Infertility
- ☐ Difficulty getting/staying pregnant
- ☐ Emotional changes with period
- ☐ Hot flashes
- ☐ Vaginal yeast infections

Men: Urology History

Do you have a history or any of the following?

- ☐ Premature ejaculation
- ☐ Erectile Dysfunction
- ☐ Prostrate problems
- ☐ Infertility

Name: _____

When was your last physical exam? Were any abnormalities found? Please explain.

Please give a brief description of what you eat and drink on a typical day, including approximate times of consumption.

Morning Afternoon Evening

What types of exercise do you do during the week? How often and for what duration?

On average, how many hours do you sleep each night? Any difficulty falling or staying asleep?

How many hours per week do you work? What type of work do you do (desk, standing, labor, etc)?

How many cigarettes do you smoke each day?
How much coffee, tea, cola or other caffeinated beverages do you drink per week?
How much alcohol do you drink per week?
Please list any use of drugs for non-medical purposes:

Check the symptoms that pertain to you:

- ☐ Cold hands/feet
- ☐ Fatigue
- ☐ Feverish in the afternoon or flushes
- ☐ Heat sensation in the hands, feet, ches
- ☐ Night sweats
- ☐ Catch colds easily
- ☐ Sweat easily
- ☐ Dizziness
- ☐ See floating black spots
- ☐ Palpitations
- ☐ Sores on tip of tongue
- ☐ Restlessness
- ☐ Anxiety
- ☐ Chest pain radiating to shoulder
- ☐ Insomnia
- ☐ Cough
- ☐ Sinus congestion
- ☐ Dry mouth, throat, nose or skin
- ☐ Allergies
- ☐ Chills alternating with fever
- ☐ Stiff neck/shoulders
- ☐ Sore throat
- ☐ Difficulty breathing
- ☐ Low appetite or Large appetite
- ☐ Loose stools or Constipation
- ☐ Abdominal bloating and/or gas after eating
- ☐ Prolapsed organs (previously diagnosed)
- ☐ Bruise easily
- ☐ General feeling of heaviness in body
- ☐ Mental heaviness, sluggishness or fogginess
- ☐ Swollen hands/feet
- ☐ Burning sensation after eating
- ☐ Bad breath
- ☐ Mouth sores/canker sores
- ☐ Bleeding, swollen, painful gums
- ☐ Heartburn and/or Belching
- ☐ Stomach pain