Patient Intake Form

Name:	Phone: Home	Cell
Street	Age Ht.	Wt.
City	Birthdate	Sex
State Zip	Occupation:	
Physician:	Referred By:	Emerg. #:
Main Problem:		Onset:
Other Concurrent Therapies	Email	

Past Medical History (include date):

Significant Illnesses: ___ Cancer ___ Diabetes ___ High Blood Pressure ___ Heart Disease ___ Hepatitis ___ Rheumatic Fever ___ Thyroid Disease ___ Seizures ___ Other.

Surgeries:

Significant Trauma (auto accidents, falls, etc.)

Birth History: (prolonged labor, forceps delivery, etc.)

Allergies: (drugs, chemicals, foods.)

Medicines taken within the last two months (include vitamins, over-the-counter drugs, herbs, etc.)

Occupational Stresses (Chemical, physical, psychological,etc.)

Exercise:

Comments:

Average daily diet:

Morning *Afternoon* *Evening*

Habits: Cigarettes Coffee Tea Cola Alcohol Drugs Sugar Salt Other ____________

Family Medical History: ___Diabetes ___Cancer ___ High Blood Pressure ___ Heart Disease ___Stroke ___ Seizures ___ Asthma ___Allergies ___Alcoholism ___ Other ____________

Notes ____________

GENERAL

☐ Poor appetite ☐ Heavy appetite ☐ Poor sleep ☐ Heavy sleep
☐ Insomnia ☐ Fatigue ☐ Tremors ☐ Vertigo
☐ Cold hands ☐ Cold feet ☐ Cold back ☐ Cold abdomen
☐ Fevers ☐ Chills ☐ Night sweats ☐ Sweat easily
☐ Cravings ☐ Localized weakness ☐ Poor coordination ☐ Change in appetite
☐ Sudden energy drop at ________ (time) ☐ Peculiar tastes/smells ____________
☐ Strong thirst (cold/hot drinks) ____________ ☐ Bleed or bruise easily (where) ____________

SKIN AND HAIR

☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching
☐ Eczema ☐ Pimples ☐ Dandruff ☐ Loss of hair
☐ Change in hair/skin texture ☐ Purpura ☐ Other hair or skin problem ____________

HEAD, EYES, EARS, NOSE, AND THROAT

☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glassses
☐ Eye strain ☐ Eye pain ☐ Poor vision ☐ Night blindness
☐ Color blindness ☐ Cataracts ☐ Blurry vision ☐ Earaches
☐ Ringing in ears ☐ Poor hearing ☐ Nose bleeds ☐ Sinus problems
☐ Mucus ☐ Dry throat ☐ Dry mouth ☐ Copius saliva
☐ Teeth problems ☐ Jaw clicks ☐ Grinding teeth ☐ Facial pain
☐ Gum problems ☐ Spots in eyes ☐ Recurrent sore throats ______/month
☐ Sores on lips or tongue ☐ Headaches (where and when) ____________
☐ Other head or neck problems ____________

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CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest Pain
- ☐ Irregular heartbeat
- ☐ Dizziness
- ☐ Fainting
- ☐ Cold hands/feet
- ☐ Swelling in hands/feet
- ☐ Blood clots
- ☐ Phlebitis
- ☐ Difficulty breathing
- ☐ Other

____

____

RESPIRATORY

- ☐ Cough
- ☐ Coughing blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Difficulty in breathing when lying down
- ☐ Tight chest
- ☐ Production of phlegm ________what color ___________.
- ☐ Other lung problems

____

____

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Gas
- ☐ Belching
- ☐ Black stools
- ☐ Bad Breath
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Bloody stools
- ☐ Sensitive abdomen
- ☐ Pain or cramps
- ☐ Laxative use:________ /week; type ________

Bowel Movement:

___________Frequency

___________Color

___________Odor

___________Texture/form

____

____

GENITO-URINARY

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Venereal disease
- ☐ Impotency
- ☐ Wake up to urinate How often________/night; time:________
- ☐ Other G/U problems

____

____

PREGNANCY AND GYNECOLOGY

- ☐ Number pregnancies
- ☐ Number births
- ☐ Premature births
- ☐ Miscarriages
- ☐ Age at first menses
- ☐ Period (days)
- ☐ Duration
- ☐ Irregular periods
- ☐ Flow (describe)
- ☐ Clots

Last PAP___________

Last menses ___________

- ☐ Vaginal discharge
- ☐ Vaginal sores
- ☐ Breast lumps

Menopause ___________

- ☐ Birth control type and duration ___________
- ☐ Changes in body/psyche prior to menstruation

____

____

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Mucscle pains
- ☐ Back pain(where) ___________
- ☐ Joint pains(where) ___________
- ☐ Other joint or bone problems?

____

____

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Poor memory
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety
- ☐ Bad temper
- ☐ Easily stressed
- ☐ Treated for emotional problems
- ☐ Considered/attempted suicide
- ☐ Other neurological or psychological problems?

____

____

COMMENTS

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Body & Mind Balance

Self Assessment

Name: ______________________ *Date:* ______________________

Rate the following 0-5: 0 (None) 1-2 (Mild) 3 (Moderate) 4-5 (Severe)

身体 (Body)	0	1	2	3	4	5
Headaches/Migraines						
Pain in Joints/Arthritis						
Back Pain						
Fatigue						
Numbness/Tingling Sensations						
Muscle Cramping/Twitching						
Restricted Motion						
Neck Pain						
Hand/Wrist Pain						
Digestion						
Hip Pain						
Foot Pain						
Eczema/Skin Problems						
Allergies/Sinus						
Over Weight						
Infertility/Libido						
Edema (Swelling)						
Muscle Fatigue						
Cold Hands/Feet						
Hormone Imbalance						

介意 (Mind)	0	1	2	3	4	5
Anxiety/Nervousness						
High Stress						
Low Productivity						
Irritability/ Low Patience						
Depression						
Motivation						
Fear						
Over Eating						
Insomnia/Poor Sleep						
Foggy Brain						
Grief/Sadness						
Indecisiveness						
Cravings						
Reduced Appetite						
Difficulty Concentrating						
Obsessive Compulsive Disorder						
Restlessness						
ADD/ADHD						
Neglecting Responsibilities						
Alcohol, Tobacco or Drug Usage						

***Total:* ____/100**

***Total:* ____/100**

Comments: ____

____

____

____

____

____

____

____

POLICIES, CONSENT AND RECORDS RELEASE AUTHORIZATION

Payment:

I understand that payment is always due the same day the treatment/service is rendered. Cash, check or credit cards are accepted. If you have insurance coverage, payment is still due at the time of service. We will provide you with the necessary information for *you* to file your claim.

Insurance

If you are a member of an insurance company we have a contract with, you are responsible for the co-payment, or a certain amount of down-payment at the time of service. You are aware that if the insurance claim is not paid in full or is denied, you are responsible to pay the remaining portion of the bill within 60 days after the service.

Cancellation:

I understand that if I need to cancel an appointment, I will give at least a 24 hours notice. If I cancel late (less then 24hrs notice) or do not call to cancel my scheduled appointment, I understand and agree to pay the full treatment cost.

Confidentiality:

At the American Alternative Healthcare Center clinic, we are committed to protecting your privacy and the confidentiality of your medical records. To this end, we have designed a comprehensive program within both of our clinics. Clinicians, interns and all other personnel have been sufficiently trained and sensitized to not only the state and federal requirements; but to the ethical handling of your personal information.

Interns, Clinicians and all other personnel:

I have been informed that this is an educational facility as well as a health care clinic. Therefore, I may encounter the assistance of student interns in the clinic. I am aware that their role as clinic personnel is to assist in the removal of needles and to perform the massage in which they are being trained to do.

Reimbursement:

I am aware that initial visits and individually paid treatments are non-refundable. Discounted packages will be reimbursed at the standard rate of $110 per visit. If there is a balance from an insurance payment, the difference will be refunded.

Release of Records:

Your medical record is the physical property of AAHC; however, the information contained in the record belongs to you and will only be released to other professionals with your written consent.

You have the rights to:

- Review and request a copy of the information used to design and carry out your treatment.
- Ask us to amend the information which you feel is wrong or incorrect.
- Ask us to restrict the information we share about you.
- Ask us to communicate with you in a certain way or place.
- Request a list of who has received your records.

By voluntarily signing below, I show that I have read, or have had read to me, the above policies, consent, and release information and have had an opportunity to ask any questions. I intend for 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 ______________________________ DATE: __________
(Or Patient Representative)
OFFICE SIGNATURE ______________________________ DATE: __________

Updated on 4/11/2008 11:28 AM

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 2 OF 2 - PLEASE SIGN BOTH SIDES

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, Tui-Na (Oriental massage), Oriental 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 Oriental 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 (Or Patient Representative) X	Date (Indicate relationship if signing for patient)

OFFICE SIGNATURE	Date

PLEASE SIGN REVERSE SIDE ALSO

PATIENT NAME

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 1 OF 2 - PLEASE SIGN BOTH SIDES

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to 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 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, and 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 wether 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 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 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 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.

PATIENT SIGNATURE X (Date)
(Or Patient Representative) (Indicate relationship if signing for patient)

PLEASE SIGN REVERSE SIDE ALSO