ACUPUNCTURE INTAKE

Name: _____

Street: _____ City, State _____Zip:_____

Home Phone:_____ Cell Phone:_____

Emergency Contact Name: _____Cell Phone: _____

E-Mail Address (for appointment confirmations)_____

Date of Birth:_____ Occupation:_____ Employer: _____

Age: _____Height:_____ Approx. blood pressure?_____ With Meds?_____

How did you hear about us?_____

What is your chief complaint or reason(s) for this visit?_____

When did you first notice symptoms? _____

_____

What improves the condition? _____

_____

What worsens the condition? _____

_____

What treatments have you tried? _____

_____

Have you received Acupuncture treatments before? YES NO

Where? _____ When? _____

By whom?_____

Are you willing to take Chinese Herbs if so prescribed by your practitioner? YES NO

REQUIRED

Pursuant to the requirements of Section 6.11, Subsection (d) V. A. C. S., article 4495b, governing the practice of Acupuncture

I, (patient's name), _____, am notifying Serasana, of the following:

YES	NO	NA	
			I have been evaluated by a physician or dentist for the condition being treated within the six months before this acupuncture treatment was performed.
			I recognize that Serasana is required to tell me: I ***should*** be evaluated by a physician for the condition being treated by the acupuncturist.

_____ (initials of patient)

Signature of Patient _____ Date: _____

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ACUPUNCTURE INTAKE

PAST MEDICAL HISTORY

- ❑ AIDS
- ❑ Alcoholism
- ❑ Eating Disorder
- ❑ Appendicitis
- ❑ Emphysema
- ❑ Arthritis
- ❑ Asthma
- ❑ Bladder Disease
- ❑ Breast Lumps
- ❑ Polio or Meningitis
- ❑ Bursitis
- ❑ Colitis/Bowel Disease
- ❑ Diabetes
- ❑ Malaria
- ❑ Elevated Liver Enzymes
- ❑ Mononucleosis
- ❑ Epilepsy
- ❑ Food, Chem, Drug Poisoning
- ❑ Gall Stones
- ❑ Neuralgia
- ❑ Goiter
- ❑ Gout
- ❑ High Cholesterol
- ❑ HIV Positive
- ❑ Typhoid Fever
- ❑ Measles
- ❑ Multiple Sclerosis
- ❑ Nephritis
- ❑ Stroke
- ❑ Hepatitis (type?)
- ❑ Chronic Fatigue
- ❑ Candida
- ❑ Cancer _____
- ❑ Thyroid problems
- ❑ Tonsilitis
- ❑ Ulcers
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Small Pox
- ❑ Hernia
- ❑ Heart Disease
- ❑ Chicken Pox

Other: _____

Surgeries: _____

Significant Traumas (auto accidents, death of loved one):_____

Allergies (drugs, chemicals, foods, airborne):_____
_____

Medications taken in the last month (include vitamins, over-the-counter drugs, herbs,...): _____
_____

CURRENT MEDICAL INFORMATION (FOR PREVIOUS 3 MONTHS)

GENERAL

- ❑ Fever
- ❑ Insomnia
- ❑ Bleed or bruise easily
- ❑ Excessive antibiotic use (episodes per year _____)
- ❑ Chills
- ❑ Excessive dreaming
- ❑ Disturbing dreams
- ❑ Cravings (what?)
- ❑ Feel cold often
- ❑ Feel hot often

SKIN AND HAIR

- ❑ Rashes
- ❑ Itching
- ❑ Loss of hair
- ❑ Acne
- ❑ Eczema
- ❑ Boils
- ❑ Hives
- ❑ Recent moles
- ❑ Premature gray

Other: _____

HEAD, EYES, EARS, NOSE, AND THROAT

- ❑ Dizziness
- ❑ Recent change in vision
- ❑ Blurry vision
- ❑ Poor hearing
- ❑ Recurrent sore throats
- ❑ Sinus problems (acute or chronic)
- ❑ Runny nose
- ❑ Gum problems
- ❑ Spots in front of eyes
- ❑ Night blindness
- ❑ Eye pain
- ❑ Dry eyes
- ❑ Red & itchy eyes
- ❑ Sores on lips or tongue
- ❑ Sneezing
- ❑ Nose bleeds
- ❑ Headaches (chronic?)
- ❑ Migraine
- ❑ Grinding teeth
- ❑ Jaw clicks
- ❑ Earaches
- ❑ Facial pain
- ❑ Nasal congestion

Other: _____

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ACUPUNCTURE INTAKE

GASTROINTESTINAL

- ❑ Nausea
- ❑ Vomiting
- ❑ Chronic laxative use
- ❑ Constipation
- ❑ Gas
- ❑ Diarrhea
- ❑ Abdominal cramps
- ❑ Indigestion
- ❑ Bad breath
- ❑ Hemorrhoids
- ❑ Belching

Other: _____

GENITO-URINARY

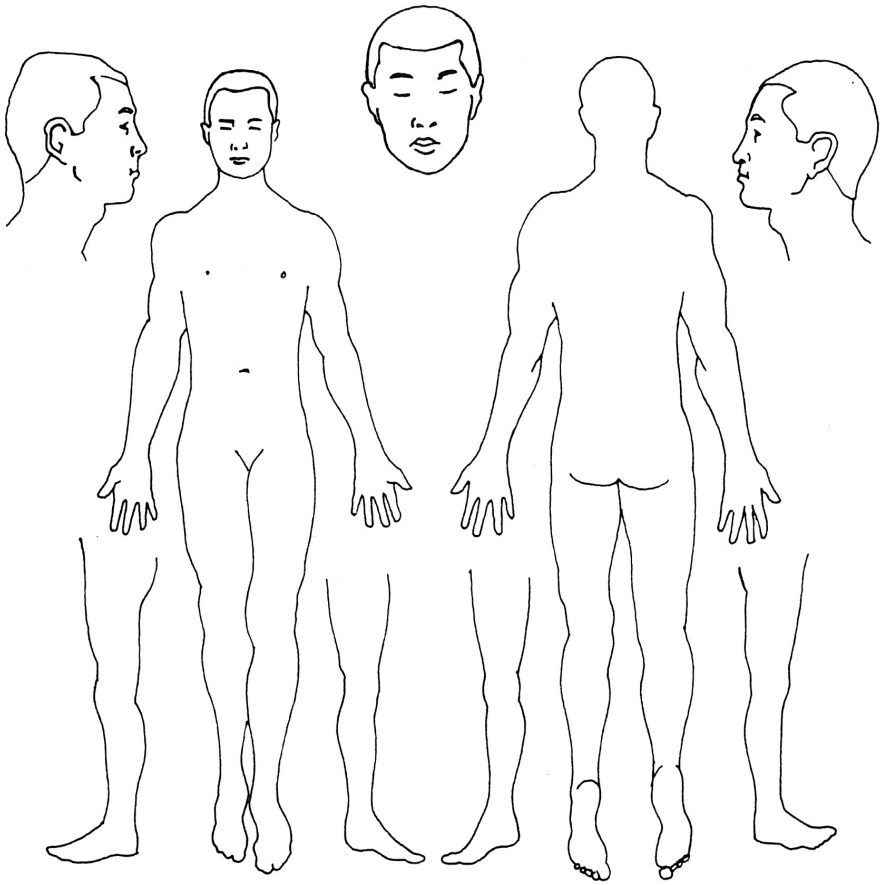
- ❑ Prostate problems
- ❑ Impotence
- ❑ Urinary Tract Infections (chronic or acute)
- ❑ Herpes (outbreaks how often?) Other:_____

MUSCULOSKELETAL

- ❑ Neck pain
- ❑ Hand/wrist pain
- ❑ Muscle weakness
- ❑ Hip pain
- ❑ Back pain
- ❑ Muscle pain
- ❑ Shoulder pain
- ❑ Elbow pain
- ❑ Back pain (radiates down back of leg)
- ❑ Knee pain
- ❑ Cortisone shots
- ❑ Back pain (radiates down side of leg)
- ❑ Foot/ankle pain

Other: _____

PLEASE MARK PAINFUL OR DISTRESSED AREAS



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ACUPUNCTURE INTAKE

CARDIOVASCULAR

- ❑ High blood pressure
- ❑ Irregular heartbeat
- ❑ Cold hands and/or feet
- ❑ Blood clots
- ❑ Low blood pressure
- ❑ Dizziness
- ❑ Swelling of hands
- ❑ Swelling of feet
- ❑ Chest pain
- ❑ Palpitations
- ❑ Fainting
- ❑ Diagnosed mitral valve prolapse

Other: _____

RESPIRATORY

- ❑ Cough (dry or productive)
- ❑ Bronchitis (acute or chronic?)
- ❑ Difficulty breathing when lying down
- ❑ Coughing blood
- ❑ Pain with deep breath
- ❑ Asthma
- ❑ Production of phlegm (color? _____)
- ❑ Pneumonia

Other: _____

NEUROPSYCHOLOGICAL

- ❑ Seizures
- ❑ Areas of numbness
- ❑ Concussion
- ❑ Bad temper
- ❑ Worry
- ❑ Physically abused
- ❑ Cry often
- ❑ Lack of coordination
- ❑ Depression
- ❑ Considered suicide
- ❑ In therapy now
- ❑ Emotionally abused
- ❑ Anxiety
- ❑ Stress
- ❑ Loss of balance
- ❑ Poor memory
- ❑ Mania
- ❑ Sexually abused
- ❑ Hospitalized for emotional issues: _____

Do you feel you get adequate affection in your life? _____

Other: _____

REPRODUCTIVE & GYNECOLOGICAL (Women Only)

_____ # of Pregnancies

- ❑ Long periods (7 days or more)
- ❑ Short periods (3 days or less)
- ❑ Painful periods
- ❑ Painful ovulation

_____ # of Births

- ❑ Irregular periods
- ❑ Clotting
- ❑ PMS - breast distension
- ❑ PMS - emotional symptoms

_____ # of Miscarriages

- ❑ Vaginal discharge (color & odor)
- ❑ Yeast infections
- ❑ Menopausal symptoms
- ❑ Birth control (what type?)

Please let your practitioner know if there is any chance you may be pregnant today.
Some acupuncture points and herbs are contraindicated during pregnancy.

Other: _____

COMMENTS

Please tell me of any other issues you would like to discuss: _____

Cancellation Policy

At Sana VIda, we all believe in respecting time. We will always do our best to prevent you from waiting before your appointments and/or having to change your appointments. We ask that, in return, you also respect our time. Please kindly give 24-hour notice if you need to change your appointment so another client can utilize that time slot. The Late Cancellation Fee is 50% of the service fee. Fees for “No Shows” equate to the full cost of the appointment missed.

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ACUPUNCTURE INTAKE

PATIENT NAME:

ARBITRATION AGREEMENT

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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

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 then be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall 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 the 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 ARBRITRATION 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: _____)

OFFICE SIGNATURE X **Date:**

AAC-FED
A2004

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ACUPUNCTURE INTAKE

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 indicated 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 teas 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 on any unanticipated or unpleasant effect associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that if may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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.

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 become pregnant.

1. There is a slight chance that a bruise may appear at the site of the needle insertion. This is due to lightly brushing a blood vessel. The bruise should dissipate within a few days. Rub the area to keep the blood circulating. This may occur at some time during your course of treatments. There will be markings on your skin after gua sha and cupping. This are expected and will dissipate in 5 – 10 days.

2. Slight swelling may occur around the insertion site. The swelling will usually dissipate within 2 to 24 hours. This is just a skin reaction and happens very rarely.

3. Slight redness may appear around the site of insertion. This is usually due to an increase of blood circulation around the needle. This is fairly common and disappears after a couple minutes or hours.

4. If the needle brushes the sheath of a nerve, the area will be sore during and after that treatment for several days. This occurs rarely.

5. You may experience some light-headedness or dizziness after a treatment. This usually lasts only a few minutes. There is no hurry for you to leave. If you need to sit for a while, please feel free to do so in the lobby.

6. You may be slightly tired after a treatment, this is due to the deep relaxation state that is created. We ask that you take your time in getting up off the treatment table.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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.

ACUPUNCTURIST NAME: X Date:

PATIENT SIGNATURE: X Date:

(Or Patient Representative: _____, Indicate relationship if signing for patient: _____)