PATIENT INFORMATION

Date: _____

E-mail: _____

Name: _____

Address: _____

_____
City State Zip

Sex: ☐ M ☐ F Age: _____ Birth Date: _____

Patient SS# _____

Occupation: _____

Employer: _____

Employer Address: _____

Employer Phone: _____ ext.

Referral Source: _____

CONTACT INFORMATION

Home Phone: _____

Work Phone: _____ ext.

Mobile Phone: _____

Best time and place to reach you: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Phone: _____

INSURANCE INFORMATION

Who is responsible for this account: _____

Relationship to Patient: _____

Insurance Company: _____

Group # _____

Member # _____

Is Patient covered by additional insurance: ☐ Yes ☐ No

Subscriber Name: _____

Birth Date: _____ SS# _____

Relationship to Patient: _____

Insurance Company: _____

Group # _____

Member # _____

ACCIDENT INFORMATION

Is condition due to accident? ☐ Yes ☐ No Date: _____

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable): _____

Attorney Phone: _____ ext.

May we contact your Attorney? ☐ Yes ☐ No

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Name: _____ Signature: _____ Date: _____

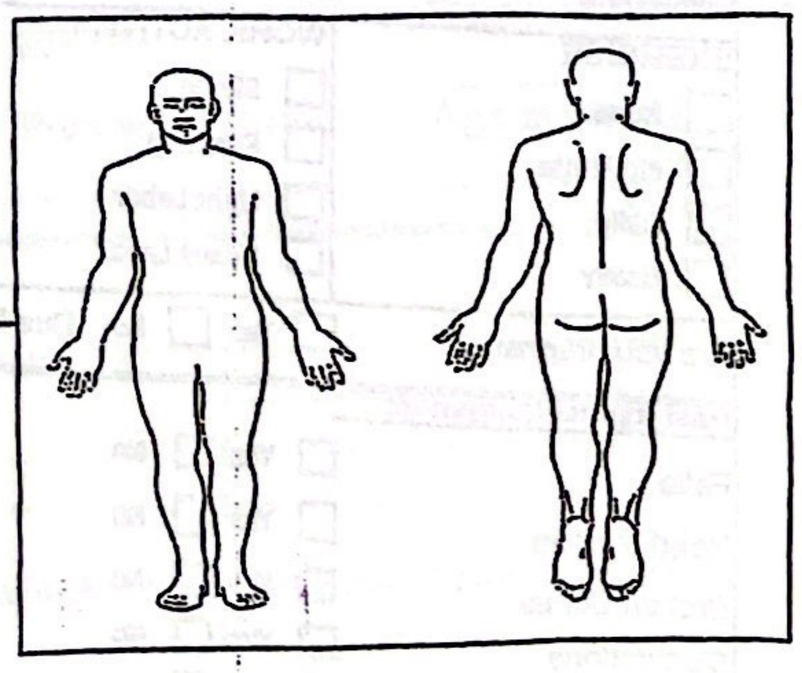
PATIENT CONDITION

Reason for Visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ YES ☐ NO ☐ UNKNOWN

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Lying on side

Activities or movements that are painful to perform:

HEALTH HISTORY

Patient Name _____

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other (specify): _____

DOCTOR(S) WHO HAVE TREATED YOU FOR YOUR CONDITION:

Name: _____ Address: _____ Phone: _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI / CT-Scan / Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS / HIV	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Polio	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Fractures	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Other: _____		
Glaucoma	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	_____		

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date: ___/___/___ (mm/dd/yy)

Past Injuries/Surgeries:			Description	Date (mm/dd/yy)
Falls	☐ Yes	☐ No		___/___/___
Head Injuries	☐ Yes	☐ No		___/___/___
Broken Bones	☐ Yes	☐ No		___/___/___
Dislocations	☐ Yes	☐ No		___/___/___
Surgeries	☐ Yes	☐ No		___/___/___

MEDICATIONS	VITAMINGS/HERBS/MINERALS	ALLERGIES
Pharmacy Name:		

General Symptoms: (Please check all that apply)

☐Poor appetite ☐Heavy appetite ☐Craves cold drinks ☐Craves hot drinks ☐Bleed or bruise easily

☐Chills ☐Cold hands or feet ☐Poor circulation ☐Night sweats ☐Sweat easily(describe): _____

_____

☐Dream-Disturbed Sleep ☐Insomnia ☐Heavy Sleep ☐Anxiety ☐Depression ☐Facial pain

☐Fatigue ☐Vertigo or dizziness ☐Blurred vision ☐Recent weight loss/gain ☐Poor Memory

☐Fever ☐Glaucoma ☐Sinus problems ☐Eczema ☐Easily Stressed

☐Hives ☐Hair Loss

☐Asthma/wheezing ☐Nose bleeds ☐Headaches ☐Migraines ☐Change in hair/skin texture

☐Difficulty breathing when lying down ☐Shortness of breath ☐Tight Chest ☐Numbness ☐Chest Pain

☐Cough: If yes, is it ☐Coughing Blood ☐Pneumonia ☐High blood pressure ☐Low blood pressure

☐Wet OR ☐Dry ☐Tachycardia ☐Blood clots ☐Irregular Heartbeat ☐Heart Palpitations

☐Thick OR ☐Thin ☐Fainting ☐Seizures ☐Bloody Stools ☐Difficulty Breathing

☐Diarrhea ☐Constipation ☐Intestinal Pain ☐Bowel Movements: Frequency per day

☐Nausea ☐Acid regurgitation ☐Vomiting _____

☐Pain on urination ☐Blood in urine ☐Frequent urination ☐Impotence

☐Lymph Nodes Removed ☐Infectious Diseases: _____

_____

Musculoskeletal: (Please check all that apply)

☐Neck/shoulder pain ☐Upper Back Pain ☐Joint Pain ☐Limited Range of Motion ☐Other: _____

☐Muscle pain ☐Low Back Pain ☐Rib Pain ☐Muscle Spasm _____

Woman Only: Gynecology

Are you pregnant? ☐Yes ☐No Duration of flow _____ ☐Irregular Periods ☐Painful Periods ☐PMS

Vaginal Discharge (Color) _____ ☐Vaginal Sores ☐Vaginal Odor ☐Clots Date Last Period began _____

Length of cycle (Day 1 to Day 1) _____ # Pregnancies _____ # Live Births _____ Premature Births _____ Age at Menopause _____

Please List Any Other Pertinent Information:

_____

_____

_____

_____

I agree that the information I provided on this intake is true. It is my responsibility to inform the Acupuncturist at any point of my course of treatments if any information has changed.

Signature of Patient_____ **Date**_____

Cancellation, Rescheduling and NO-show Policy

If you need to cancel or reschedule an appointment, please be sure to give **24 hours** notice. I reserve the right to charge the full appointment fee if 24 hours notice isn't given.

In case of a **no-show**, you will be charged **100%** of the appointment fee.

Thank you for your cooperation.

Cheri Gross

Signed_____ Date_____

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 California 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 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 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 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.

PATIENT SIGNATURE **X** (Date)

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

OFFICE SIGNATURE **X** (Date)

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 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 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. 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 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.

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:

PATIENT SIGNATURE **X** (Date)

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE