



New Patient Information

Today's date _____

Name _____

Address _____ City _____ State ____ Zip _____

Home # _____ Work # _____

Mobile # _____ Primary Contact # Home Work Mobile

Email _____ Would you like appointment confirmations by email? Yes

How did you hear about us? _____

Sex: Male Female: are you pregnant? Yes: due date: _____ no

Date of birth _____ age _____ Place of birth _____

Education (highest level attained) _____ occupation _____ how long _____

Marital status single married separated divorced co-habiting

Family History		Alive? Present health	Deceased? Cause of death
Father		<input type="checkbox"/>	<input type="checkbox"/>
Mother		<input type="checkbox"/>	<input type="checkbox"/>
Spouse		<input type="checkbox"/>	<input type="checkbox"/>
Brothers	How many?		
Sisters			
Children			

Check illnesses that have occurred in any of your blood relatives:

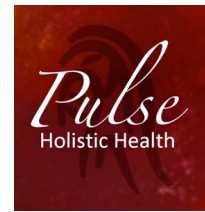
- Alcoholism
- Allergies
- Bleeding tendency
- Cancer
- Diabetes
- Heart disease
- High blood pressure
- Kidney disease
- Mental illness
- Nervous illness
- Obesity
- Stroke
- Tuberculosis
- Other _____

Major concerns (What is the reason for this visit?)

1. _____

2. _____

3. _____



Personal Medical History

How would you describe your health as a child? _____

Check any illnesses or conditions you have or had in the past:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Bleeding tendencies |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High fevers |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Nervous disorder | <input type="checkbox"/> Heart trouble |
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Measles | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Antibiotic use |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Gonorrhoea | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Asthma | _____ |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vein trouble | _____ |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Allergies | <input type="checkbox"/> High blood pressure | |

List illnesses not requiring operation for which you were hospitalized: none

List illnesses requiring surgery (date and doctor): none

List any other serious injury, broken bones, scars etc: none

List any allergies or sensitivity to any medicines or other substances: none

Weight: _____ How long have you been at this weight? _____

Check the disease that you have been immunized for:

- Smallpox Tetanus Typhoid Influenza Polio Other _____

Have you ever taken cortisone type drugs? No Yes: when/how long? _____

Date of last: Physical _____ Cholesterol test _____
 HIV test _____ Prostate test _____
 Pap smear _____ Mammography _____
 Blood tests (which?) _____

Results of any of the test listed?

Comments (anything else you would like to tell us):

Patient Symptom Survey

Name: _____ Date: _____

Please check your past and present symptoms so we can better evaluate your concerns

GENERAL

- Past now
- fatigue
 - sleep problems
 - swollen glands
 - hot or cold intolerance
 - frequent headaches
 - weight loss
 - weight gain
 - fever or chills
 - allergies

NERVOUS SYSTEM

- dizziness
- blurred vision
- fainting
- paralysis
- tremors
- numbness/tingling
- convulsions
- imbalance
- memory loss
- muscle weakness

URINARY

- painful urination
- frequent urination
- hard to urinate
- incontinence
- bed wetting
- discolored urin
- frequent infections
- prostate problems
- unusual discharge

HEAD

- headache
 - entire head
 - back of head
 - forehead
 - temples
 - migraine
- head feels heavy
- loss of memory
- light-headedness
- fainting
- light bothers eyes
- loss of smell
- loss of taste
- loss of balance
- dizziness
- loss of hearing
- pain in ears
- ringing in ears
- buzzing in ears

NECK

- pain in neck
- neck pain with movement
- pinched nerve in neck
- neck feels out of place
- stiff neck
- muscle spasms in neck

EMOTIONAL

- Past now
- anxiety or worry
 - frequent crying
 - anger
 - tension
 - mood swings
 - fear
 - restlessness
 - confusion
 - depression
 - suicidal

REPRODUCTIVE SYSTEM

- painful intercourse
 - prostate problems
 - sexual problems
 - loss of sex drive
 - genital infections
- birth control methods _____

WOMEN ONLY

- cramps
 - PMS
 - Irregular periods
- Are you pregnant? ___ Yes ___ No
- Date of last period _____
- # of pregnancies _____
- # of miscarriages _____
- # of abortions _____
- Date last PAP _____
- Difficult labor
 - Breast problems

LOW BACK

- low back pain
- back pain is worse when:
 - working
 - lifting
 - stooping
 - sitting
 - bending
 - coughing
- pinched nerve in low back
- slipped disk
- low back feels out of place
- muscle spasms
- arthritis

MID BACK

- mid back pain
- pain btw shoulder blades
- sharp stabbing pain
- muscle spasms

CHEST

- chest pain

EENT

- earache
- ear discharge
- ringing in ears
- hearing loss

Past now

- nosebleeds
- hoarseness
- problems swallowing
- sore throat
- jaw tight or sore
- dental problems
- glasses/contacts

MUSCULOSKELETAL

- joint swelling
- muscle cramps
- neck pain
- shoulder pain
- tennis elbow
- arm pain
- hand sensations
- loss of grip
- midback pain
- rib pain
- low back problems
- hip pain
- foot problems
- leg cramps
- knee pain
- ankle weakness
- tingling foot

SHOULDERS

- pain in shoulder joint
- pain across shoulders
- bursitis (r-l)
- arthritis (r-l)
- can't raise are:
 - above shoulder level
 - over head
- tension in shoulders
- pinched nerve in shoulder
- muscle spasms in shoulders

ARMS & HANDS

- pain in upper arm
- pain in forearm
- pain in hands
- pain in fingers
- pinched nerve in arm
- pinched nerve in fingers
- pins & needles in arms
- pins & needles in fingers
- fingers go to sleep
- hands cold
- swollen joints in fingers
- arthritis in fingers
- loss of grip strength
- heart/lung
- chest pain
- high blood pressure
- low blood pressure
- persistent cough
- hard to breathe
- coughing blood
- coughing phlegm

Past now

- irregular heartbeat
- varicose veins
- ankle swelling

GASTROINTESTINAL

- change in appetite
- thirst
- nausea
- vomiting
- diarrhea
- constipation
- gas
- hemorrhoids
- gall bladder
- belching
- heartburn
- abdominal pain
- bloody/black stools
- indigestion
- liver trouble

SKIN

- easy bruising
- dry skin
- itching
- boils
- rashes
- excessive sweat
- hair changes

HIPS, LEGS & FEET

- pain in buttocks (r-l)
- pain in hip joint (r-l)
- pain down leg (r-l)
- pain down both legs
- leg cramps (r-l)
- pins & needles in legs (r-l)
- numbness of leg (r-l)
- numbness of feet (r-l)
- numbness of toes (r-l)
- feet feel cold
- cramps in feet (r-l)
- swollen ankles (r-l)
- swollen feet (r-l)
- painful joints in toes (r-l)
- pain in foot (r-l)
- pain in knee (r-l)

GENERAL

- nervousness
- irritable

Patient name: _____

Date: _____

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 processes 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 the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the health care provider including any heirs or past, present or future spouses(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 or preceptorship 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 or punitive damages. Filing of any action in any court for the health care provider to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claims. However, following the assertion of any claim against the health care provider, any fee dispute, whether or not the subject of an existing court action, shall also be resolved by arbitration.

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 arbitrator appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide to arbitration. Each party to the arbitration shall pay such a 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 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 loss 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 all 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 as 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.

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 provisions of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full 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 AND COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE

(or patient representative)

(indicate relationship if signing for patient)

PLEASE SIGN REVERSE SIDE ALSO

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 acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories on this form or not.

I realize that acupuncture may be considered as an investigative procedure in the United States. There are some risks to treatment including but not limited to some bruising of the skin and/or slight bleeding. The risk of infection is small when all needles are sterile. Needles are considered sterile when they are either disposable or are autoclaved according to California State Board requirements.

I have had an opportunity to discuss with the acupuncturist name below and/or with other office or clinic personnel the nature and purpose of acupuncture. I understand that results are not guaranteed.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts know, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my precondition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE

(or patient representative)

(indicate relationship if signing for patient)

PLEASE SIGN REVERSE SIDE ALSO

OFFICE SIGNATURE

DATE