Health History For Acupuncture

Date: ____/____/____

Name	Gender	Age	Date of Birth _____/_____/_____
Address	City	State	Zip Code

Phone #
- ☐ Home _____
- ☐ Cell _____
- ☐ Other _____

email _____

Emergency Contact_____

Contact Phone # _____

Relationship _____

Occupation:	Height _____ Weight _____	Physician Name Physician Address Physician Phone #

Have you been treated by Acupuncture or Oriental Medicine before?

☐No ☐Yes .... Last Treatment _____/_____/_____

Relationship status

☐ Single ☐ Divorced
☐ Married ☐ Widowed
☐ Living w/Partner ☐ Other
☐ Separated

How did you hear about our clinic?

Main Concerns

When did this start? _____

Pain level- *please circle*

Pain Scale

Heat makes it:	Better	no change	worse
Cold makes It	Better	no change	worse
Damp makes it:	Better	no change	worse
Exercise makes it	Better	no change	worse

Other Health Concerns

1

2

3

Health History

	You	Year	Family		You	Year	Family
☐ Cancer – type(s) _____				☐ Osteoporosis			
☐ Diabetes				☐ Herpes			
☐ Hepatitis				☐ Aids/HIV			
☐ High Blood Pressure				☐ Other STD			
☐ Heart Disease				☐ Rheumatic Fever			
☐ Stroke				☐ Alcoholism			
☐ Seizure				☐ Allergies –Types _____			
☐ Thyroid Disease				☐ Mental Illness			
☐ Asthma				☐ Kidney Disease			
☐ Pacemaker				☐ Anemia			

Habits

Amount/Frequency

Coffee/Tea _____
Tobacco _____
Alcohol _____
Drugs _____

Exercise

Regularly? ☐ Yes ☐ No

If so, what and How Often:
_____

Medications

Please note what medications, herbs or supplements you use regularly

Medicine/Vitamins	Dosage	Reason	How Long?

Injuries & Surgeries

Please note area of body & date

Temperature

How warm / cold you feel (not in degrees) relative to other people?
do you wear more or less layers, etc.

Please indicate your body's overall relative Temperature Along The Line With An ***X***

COLD ◄——————————————► HOT

☐ Cold hands/ feet
☐ Chills
☐ Cold "in the bones"
☐ Areas of numbness

☐ Excessive thirst
☐ Thirst for cold /hot drinks
☐ Thirst, no desire to drink
☐ Absence of thirst

☐ Night sweats
☐ Unusual sweats

When? _____*am / pm*
*Where on body*_____

☐ Hot hands, feet, chest
☐ Hot flashes
☐ Hot in afternoon
☐ Hot at night

Moisture

Please indicate your body's relative moisture level along the line with an ***X***
Hair, skin, mouth, etc.

DRY ◄——————————————► OILY

☐ Dry skin
☐ Dry hair
☐ Dry eyes
☐ Dry brittle nails

☐ Dry mouth
☐ Dry lips
☐ Dry throat
☐ Dry nose /Nosebleeds

☐ Edema /Swelling_____
☐ Rashes_____
☐ Itching _____
☐ Dandruff

☐ Weight gain / loss
☐ Oily skin
☐ Oily hair
☐ Pimples

Digestion

Please indicate your body's overall digestion along the line with an ***X***

DIARRHEA ◄——————————► CONSTIPATION

BM: How often? _____x / every _____days

- ☐ Alternating diarrhea & constipation (IBS)
- ☐ Indigestion
- ☐ Gas
- ☐ Belching
- ☐ Bloating
- ☐ Nausea / Vomiting
- ☐ Bad breath
- ☐ Dry Stools
- ☐ Difficult to pass
- ☐ Tired after BM
- ☐ Excessive hunger
- ☐ Poor appetite
- ☐ Ulcer
- ☐ Hemorrhoids

ENERGY

Please indicate your body's overall energy level along the line with an ***X***

LOW ◄——————————► HIGH

- ☐ Sudden energy drop
  Time of day: _____ am / pm
- ☐ Energy drop after eating
- ☐ Fatigue
- ☐ Dependence on caffeine
- ☐ Wired / ungrounded feeling
- ☐ Body / Limbs feel heavy
- ☐ Body / Limbs feel weak
- ☐ Shortness of breath
- ☐ Heart Palpitations
- ☐ Blood pressure High / Low
- ☐ Bleed / Bruise easily
- ☐ Hard to concentrate
- ☐ Poor memory
- ☐ Dizziness / lightheaded
- ☐ Headaches _____x / week

Female Reproductive

Are you sexually active? Y ☐ N ☐

MENSES (If applicable)

Age at first menses _____
Length of full cycle _____ days
Length of menses ____ days
Last menses start date ____ / ____
# of pregnancies ____
# of births ___premature ___Miscarriages
___Abortions

- ☐ Birth control pill (hormonal)
- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation (PMS)
- ☐ Cramps Before bleeding___
  First day___During period___
- ☐ Fatigue w/ menses
- ☐ Digestive changes w/ menses
- ☐ Mid-cycle spotting
- ☐ Yeast infections

MENOPAUSE

Age changes began _____
Age at last menses _____

- ☐ Hot flashes _____x/ day
- ☐ Vaginal dryness
- ☐ Night sweats _____x / week
- ☐ Loss of sex drive

Male Reproductive

Are you sexually active? Y ☐ N ☐

- ☐ Change of sexual drive
- ☐ Erectile dysfunction
- ☐ Premature ejaculation
- ☐ Sores on genitals
- ☐ Discharge
- ☐ Prostate disease
- ☐ Genital Pain
- ☐ Jock Itch
- ☐ Vasectomy
- ☐ Hernia
- ☐ Hemorrhoids

Emotions

What emotion(s) dominate your experience?

- ☐ Anger
- ☐ Irritability
- ☐ Anxiety
- ☐ Worry
- ☐ Obsessive thinking
- ☐ Sadness
- ☐ Grief
- ☐ Depression
- ☐ Fear
- ☐ Timid / shy
- ☐ Indecision

Urinary (if applicable)

- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Difficulty starting / stopping
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Pain on urination
- ☐ Burning sensation
- ☐ Cloudy urine
- ☐ Blood in urine

Sleep

hours per night _____

- ☐ Difficulty falling asleep
- ☐ Wake ___x/ night @_____am / pm
- ☐ Wake to urinate *How often?*_____
- ☐ Disturbing dreams
- ☐ Restless sleep
- ☐ Not rested upon waking

Head, Eyes, Ears, Nose, Throat

- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Excess earwax

- ☐ Sore throat
- ☐ Frequent Coughs
- ☐ Swollen Glands
- ☐ Hoarseness
- ☐ Trouble Swallowing
- ☐ Poor vision
- ☐ Night Blindness

- ☐ Headache
- ☐ Migraine
- ☐ Head Injury
- ☐ Dizziness
- ☐ Vertigo
- ☐ Hay Fever

- ☐ Sinus congestion
- ☐ Nose Bleeds
- ☐ Loss of Smell
- ☐ Phlegm (*color*_____)

- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Teary Eyes
- ☐ Dry Eyes
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Spots in front of eyes

- ☐ Dental problems
- ☐ Mouth sores
- ☐ Jaw Problems /TMJ
- ☐ Teeth Grinding

Gina Renee, L.Ac.

ACUPUNCTURE BEAUTY WELLNESS

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 California and federal law provide 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 healthcare 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 healthcare provider and/or other licensed healthcare 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 healthcare provider, including those working at the healthcare 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 healthcare provider, and/or the healthcare 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 equal 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, where not in conflict with this agreement, the Arbitration Rules of ADR Services, Inc. shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of the ADR Services rules are available on its website at www.adrservices.com or by calling 213-683-1600 to request a copy of the rules.

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 healthcare 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 Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: _____ Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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 appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

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, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). 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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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 NAME:

ACUPUNCTURIST NAME: Gina Renee, L.Ac

(Date)

PATIENT SIGNATURE **X**

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

Gina Renee, L.Ac.

ACUPUNCTURE BEAUTY WELLNESS

SESSION RESCHEDULE/ CANCELLATION / LATE POLICY:

*Please notify me **at least 2 business days or 48 business hours in advance** if you cannot keep your appointment.*

*You can reach me by phone or text at **831-220-5689***

All appointments cancelled or rescheduled with less than 48 hours advance notice will be charged 50% of the scheduled appointment fee.

In the event of a missed appointment without any notification of cancellation or rescheduling ("no-call, no-show"), you will be charged the full cost of the scheduled appointment fee. This includes appointments that are made as part of a package. If you do not call and do not show for a scheduled appointment as part of a package, you will forfeit that session.

Late appointments are considered cancelled and forfeited 20 minutes past the scheduled appointment time without advance notice, and you will be billed for the full cost of the session. *Please contact me at 831-220-5689 if you are running late.*

Thank you for your courtesy and understanding.

Gina Renee L.Ac.

Gina Renee, L.Ac., Dipl.Ac.(NCCAOM) - 831.220.5689 - www.GinaReneeLac.com