

acupuncture profile & release form

Patient Information

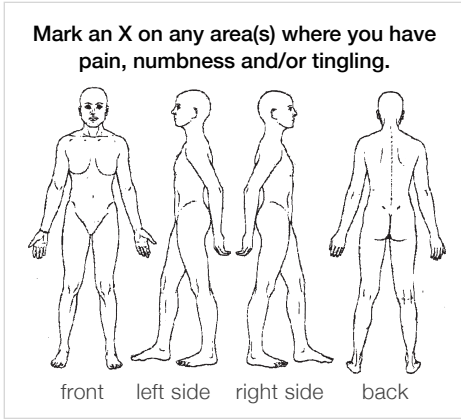
First Name _____ M.I. _____ Last Name _____
 Address _____ Home Phone _____
 City _____ State _____ Zip _____ Cell Phone _____
 Email _____ Sex M F Age _____ Birthdate _____ / _____ / _____
Month Day Year
 Height _____ Ft. _____ In. Weight _____ Lbs. Marital Status Single Married Partnered Separated Divorced Widowed
 Occupation _____ Employer _____
 How did you hear about us? _____ Email me monthly exclusive spa specials Yes No

Patient Condition

Reason for Visit _____
 Has this condition been diagnosed by a physician or other provider? Yes No
 If yes, diagnoses _____
 Are you being treated for this condition by anyone else? Yes No If yes, describe _____
 Have these treatments helped? Yes Somewhat Not Much Not At All
 How does this condition affect you? _____
 How long have you had this condition? _____

Please answer the following questions if you have pain:

Is the condition getting progressively worse? Yes No Unknown
 Rate the severity of your pain (0=no pain to 10=severe pain) _____
 Type of pain: Sharp Burning Throbbing Numbness Aching Swelling Dull
 Tingling Stabbing Shooting Stiffness Other _____
 How often do you have this pain? _____
 Describe your pain: Constant Comes and Goes Other _____
 Activities/Movements painful to perform: Sitting Standing Lying Down
 Walking Bending Other _____



Health History

Do you have seizures? Yes No
 Do you have high blood pressure? Yes No
 Do you have Diabetes? Yes No
 Do you have an infectious disease? Yes No Possibly
 If yes, please identify: HIV/AIDS Hepatitis B Hepatitis C Flu/Cold Streptococcus Mononucleosis Tuberculosis
 Other _____
 Are you taking any type of blood thinner? Yes No
 Do you have a pacemaker? Yes No
 Have you ever had an Acupuncture treatment? Yes No
 Do you have any type of heart problem? Yes No If yes, specify _____
 Do you have any known or suspected allergies? Yes No If yes, specify _____

Health History

Indicate if you *currently have or have ever had* any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fracture	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol/Drug Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies/Sinus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Head/Neck Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated/Bulging Disc	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Atherosclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	High/Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Clot	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Dislocation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sciatica	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scoliosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spinal Fracture	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bursitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spinal Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Back Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sprain/Strain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Carpal Tunnel Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Meningitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tendonitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Decreased Sensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tennis/Golfer's Elbow	<input type="checkbox"/> Yes <input type="checkbox"/> No
Degenerative Disc	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	TMJ	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness/Vertigo	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Earache	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck Pain/Stiffness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor/Growth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Uneven Leg Length	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss/Gain	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other _____

Describe/explain any treatment(s) you have had or are currently receiving for any of the conditions checked 'Yes' above. _____

List all past/present injuries, dislocations, broken bones and/or surgeries with date.

_____	Date _____
_____	Date _____
_____	Date _____
_____	Date _____
_____	Date _____

Medications & Supplements

List all medications, vitamins, minerals and/or herbs you are currently taking and reason.

Health History

Family Health History

Mother Living Deceased Reason for death _____
Father Living Deceased Reason for death _____
Maternal Grandmother Living Deceased Reason for death _____
Maternal Grandfather Living Deceased Reason for death _____
Paternal Grandmother Living Deceased Reason for death _____
Paternal Grandfather Living Deceased Reason for death _____

WOMEN ONLY:

Are you pregnant? Yes No Trying Maybe If yes, how many weeks? _____

Method of birth control? _____

Age of First Menses: _____ Date of Last Menses: _____ Age of Menopause: _____

Typical Length of Menses (days you bleed): _____ Typical Length of Cycle (from 1st day of one cycle to 1st day of next): _____

Number of: Pregnancies _____ Births _____ Abortions _____ Miscarriages _____

Hysterectomy? Yes No If yes, partial or complete? _____ Date _____

Check all that apply to you:

Scanty Flow Abnormal Pap Smear Breast Lumps Irregular Cycles Infertility
 Heavy Flow Menopausal Symptoms Nipple Discharge Low Libido Fibroids
 Clotting Premenstrual Problems Fibrocystic Breasts Excessive Libido Endometriosis
 Vaginal Discharge Painful Periods Bleeding Between Cycles Painful Intercourse Ovarian Cysts
 Other _____

MEN ONLY:

Check all that apply to you:

Low Libido Impotence Seminal Emissions Prostate Problems Testicular Redness
 Excessive Libido Painful Intercourse Premature Ejaculation Testicular Pain Testicular Swelling
 Vasectomy Date _____ Other _____

Lifestyle

Diet: Normal Vegetarian Vegan Lactose-free Gluten-free Other _____

Foods you crave: _____ When? _____

Daily Intake: Water _____ Soda _____ Caffeine? Yes No Coffee _____ Caffeine? Yes No Tea _____ Caffeine? Yes No

Do you drink alcohol? Yes No If yes, how much? _____ How often? _____ What kinds? _____

Do you smoke cigarettes? Yes No If yes, how many per day? _____

Do you use any other type of tobacco? Yes No If yes, what type and how often? _____

Have you smoked cigarettes or used other tobacco in the past? Yes No If yes, when did you stop? _____

Do you use recreational drugs? Yes No If yes, what type and how often? _____

Have you used recreational drugs in the past? Yes No If yes, when did you stop? _____

Do you have a high stress level? Yes No If yes, explain _____

Do you exercise? Yes No If yes, how often? _____ What kind? _____

Personal Health Inventory

Please put a check mark (✓) by the symptoms that you have now.
Place a star (*) next to the ones you have noticed within the last three months.

Qi, Blood, Yin, Yang

- anxiety
- catch colds easily or frequently
- chest pain traveling to shoulder
- cold feet
- cold hands
- difficult to concentrate
- dizziness
- dream disturbed sleep
- dry skin
- fatigue
- feverish in the afternoon or flushes
- general weakness
- heat sensations in hands, feet, chest
- insomnia
- mental confusion
- night sweats
- palpitations
- restlessness
- sores on tip of tongue
- speech problems
- sweat easily
- thirst, at night
- feel worse after exercise
- see floating black spots

LU

- allergies
- chills alternating with fever
- cough
- difficulty breathing
- dry mouth, throat, nose
- feeling achy
- headaches
- nasal discharge
- nose bleeds
- shortness of breath
- sinus congestion
- sneezing
- sore throat
- stiff neck/shoulders

SP

- abdominal bloating and/or gas after eating
- belching
- chest congestion
- constipation
- diarrhea
- eating disorder
- fatigue after eating
- gas
- general feeling of heaviness in body
- hemorrhoids
- loose stools
- low appetite
- mental heaviness, sluggishness or fogginess
- nausea
- prolapsed organs (previously diagnosed)
- swollen feet
- swollen hands
- bruise easily

ST

- bad breath
- belching
- bleeding, swollen or painful gums
- burning sensation after eating
- constipation
- heartburn
- large appetite
- mouth sores (canker or cold sores)
- stomach pain
- vomiting

HT/PC

- chest pain
- edema
- high blood pressure
- insomnia
- low blood pressure
- palpitations
- stroke
- varicose veins

LR/GB

- bitter taste in mouth
- blood shot eyes
- blurred vision
- chest pain
- convulsions
- diarrhea alternating with constipation
- difficulty swallowing
- dry eyes
- feeling of a lump in the throat
- headache at top of the head
- hot flashes
- muscle spasms, twitching, cramping
- numbness of hands and feet
- pain in rib cage
- red, sore or irritated eyes
- seizures
- skin rashes
- tight feeling in chest
- TMJ or locked jaw
- anger easily
- feel better after exercise

KI/BL

- frequent urination
- hair loss
- joint pain
- lack of bladder control
- loose teeth
- low back pain
- memory problems
- night blindness or low vision
- ringing in your ears
- sore, cold or weak knees
- get up more than one time at night to urinate

Other

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Village Health Wellness Spa 'Notice of Privacy Practices'. This notice describes how Village Health Wellness Spa may use and disclose by protected health information, certain restrictions on the use and disclosure of my healthcare information, and the rights that I have regarding my protected health information.

Sign Here
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Signature of Patient, Guardian or Personal Representative

Relationship to Patient

Date

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.

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 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 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 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 of notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal stature 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 thirty 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 the 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.

Sign Here
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Signature of Patient, Guardian or Personal Representative

Relationship to Patient

Date

Informed Consent

What is Acupuncture? Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body.

Is Acupuncture Safe? Acupuncture is generally very safe. Serious side effects are rare – less than one per 10,000 treatments.

Does Acupuncture Have Side Effects?

You need to be aware that:

- Drowsiness occurs after treatment in a small number of patients and, if affected, you are advised not to drive.
- Minor bleeding or bruising occurs after acupuncture in about 3% of treatments.
- Pain during treatment occurs in about 1% of treatments.
- Symptoms can get worse after treatment (less than 3% of patients). You should tell your acupuncturist about this, but it is usually a good sign.
- Fainting can occur in certain patients, particularly at the first treatment.

In addition, if there are particular risks that apply in your case, your practitioner will discuss these with you.

Is There Anything Your Practitioner Needs to Know?

Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced a seizure, dizziness, or fainting episode
- If you have a pacemaker or any other electrical implants
- If you have a bleeding disorder
- If you are taking anti-coagulants or any other medications
- If you have damaged heart valves or have any other particular risk of infection

SINGLE-USE, STERILE, DISPOSABLE NEEDLES ARE USED IN THE CLINIC.

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 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 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 acknowledge that Acupuncture may be considered as an investigative procedure in the United States and fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

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 my treatment for my present condition and for any future condition(s) for which I seek treatment.

Sign Here
→

Signature of Patient, Guardian or Personal Representative

Relationship to Patient

Date

Pediatric Consent (If patient under the age of 18)

N/A (I am age 18 or older)

I, being the parent or legal guardian of _____ (**patient name**), hereby consent to the treatment of my child by Village Health Wellness Spa. I understand that the nature of the treatment may include examination, acupuncture treatment, recommendation of herbal formula(s), and/or various ancillary procedures such as cupping, herbal rub, ear seeds and moxibustion.

Signature of Patient, Guardian or Personal Representative

Relationship to Patient

Date