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guest name .....

guest date of birth ..../..../....

TRADITIONAL EASTERN THERAPIES PROFILE

what brings you here today? .....

.....

if related to a condition, how did it develop? .....

how long has this condition persisted? .....

have you ever received any treatment for this condition? yes / no

if yes, where? ..... what was the diagnosis? .....

when? ..... what kind(s) of treatment(s)? .....

by whom? ..... what were the results of treatment? .....

please list substances that you are allergic to. .....

list medications you are currently taking.

medications	strength	how many per day	for how long
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

list any major surgeries you have had.

date	description
.....	.....
.....	.....
.....	.....

significant trauma (auto accident, falls, etc.) .....

.....

NOTICE TO THE ACUPUNCTURIST

(Pursuant to the requirement of Section 6.11, subsections (b) through (d) V.A.C.S. article 4495b, governing the practice of acupuncture.)

yes / no I have been evaluated by a physician or dentist for the condition being treated within the 12 months prior to the acupuncture treatment. I recognize that I should be evaluated by a physician for the condition being treated by the acupuncturist.

or

yes / no I have received a referral from my chiropractor within the last 30 days prior to the acupuncture treatment.

After being referred by a chiropractor, if after 30 days or 20 sessions, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice to follow this advice. By signing below, I confirm that the information provided is accurate.

guest signature ..... date .....

name ..... date .....

please check (√) symptoms you currently have or have had in the past year.

GENERAL

..... anxiety
..... chills
..... depression
..... fatigue
..... fevers
..... forgetfulness
..... headache
..... insomnia
..... mood swings
..... sweats
..... weight gain
..... weight loss

LIFESTYLE

..... alcohol
..... caffeine
..... exercise
..... smoking
..... stress
..... weight control

SKIN

..... blood not clotting
..... bruise easily
..... discoloration
..... lumps in groins
..... lumps underarm
..... skin problem

GENITOURINARY

..... abnormal urine color
..... blood or pus in urine
..... burning urination
..... frequent urination
..... kidney stone
..... poor bladder control
..... urgency to urinate

EYE, EAR, NOSE, MOUTH, THROAT

..... blurred vision
..... bleeding gums
..... cataracts
..... double vision
..... earache
..... ear discharge
..... eye pain/strain
..... glasses
..... hearing loss
..... hoarseness
..... nosebleeds
..... olfactory issues
..... recurrent sore throat
..... red/inflamed eye
..... ringing in ears
..... sinus issues
..... sores on lips / tongue
..... taste change
..... teeth issues
..... vision – halos

GASTROINTESTINAL

..... abdominal pain
..... black stools
..... gas/bloating
..... blood in stools
..... constipation
..... diarrhea
..... difficulty swallowing
..... heartburn/reflux
..... hemorrhoids
..... nausea
..... poor appetite
..... stomach pain
..... vomiting
..... vomiting blood

RESPIRATORY

..... asthma
..... coughing blood
..... night sweats
..... persistent cough
..... phlegm production
..... recurrent bronchitis
..... shortness of breath

CARDIOVASCULAR

..... chest pain
..... high/low blood pressure
..... irregular heart beat
..... poor circulation
..... swelling of ankles
..... varicose veins

MUSCULOSKELETAL

..... arm/hands
..... back
..... feet/legs
..... hips
..... joints
..... muscle
..... neck
..... shoulders

SIGNIFICANT ILLNESS

..... rheumatic fever
..... thyroid disease
..... venereal disease
..... heart disease
..... cancer
..... AIDS or HIV positive
..... diabetes
..... hepatitis
..... seizures
..... other

NEUROLOGICAL

..... convulsions
..... fainting
..... handwriting change
..... paralysis
..... tremor/clumsiness
..... vertigo/dizziness

MEN ONLY

..... breast lump
..... genital pain
..... impotence
..... lump in testicles
..... penis discharge

WOMEN ONLY

..... abnormal pap smear
..... bleeding between periods
..... breast lump
..... contraceptives
..... irregular periods
..... menopausal
..... painful periods
..... sores on genitalia
..... vaginal discharge

number of:

..... pregnancies
..... miscarriages
..... children
..... abortions

date of last menstrual period:

.....

last pap smear:

.....

have you had a mammogram?

.....

are you pregnant?

.....

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ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 1 OF 2

name ..... date .....

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 relations 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 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 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 the 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 statue 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 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.

signature ..... date .....

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ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 2 OF 2

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 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. 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 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.

signature ..... date .....

office
signature ..... date .....