ORIENTAL MEDICAL HISTORY

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have any questions, please ask.

PERSONAL INFORMATION: TODAY'S DATE_____

NAME_____EMAIL_____
HOME PHONE_____ CELL_____WORK_____
ADDRESS_____CITY,ST, ZIP_____
DATE OF BIRTH_____AGE_____ HEIGHT_____WEIGHT_____
MARITAL STATUS_____# OF CHILDREN & AGES_____
OCCUPATION_____SSN_____
EMPLOYER_____
INSURANCE CO._____PHONE#_____
MEMBER ID_____GROUP #_____
NAME POLICY IS UNDER_____D.O.B._____
WHOM MAY WE THANK FOR REFERRING YOU?_____
HAVE YOU EVER HAD ACUPUNCTURE OR ORIENTAL MEDICINE TREATMENT BEFORE?_____
IN CASE OF EMERGENCY CONTACT_____

CHIEF COMPLAINT (please describe in your own words what you experience)_____
_____
_____
_____
_____
_____
When did this problem begin?_____
Diagnosis by an MD?_____
Lab results for the above_____
Characteristics?_____
How often?_____
What makes it feel better?_____Worse?_____
What other forms of treatment have you sought?_____
_____
_____
Hospitalizations/Surgeries (Please include dates):_____
_____
_____
List any other health problems you now have_____
_____
_____

List any allergies, food sensitivities or food cravings you have_____
_____
_____
Have you had your tonsils removed?_____Appendix?_____Gall Bladder?_____
Have you had oral surgery?_____Please list_____
When was the last time you have taken antibiotics?_____
Do you have a pacemaker?_____Taking Coumadin/Warfarin?_____
Have you ever had chemotherapy?_____
Radiation Therapy?_____
Are you current under the care of a physician?_____
Or a therapist?_____
Have you recently had any unusually stressful experiences (i.e. divorce, death of someone close, bankruptcy, loss of job, illness, injury, etc)?_____
_____
_____
What type of exercise do you get and how often?_____
_____
Have you ever been alcohol or drug dependent? When?_____
How much tobacco do you use per day?_____Marijuana?_____Other_____

Please describe your average daily diet:

Morning_____
Afternoon_____
Evening_____
Snacks_____
Please list any dietary restrictions_____
How much of the following do you drink per day? Coffee (cups) _____ Tea (cups) _____
Water (oz)_____Soft Drinks (cans)_____Wine (glass)_____Beer (oz)_____Liquor (oz)_____

Family Medical History Please check the diseases which other members of your family had:

__Cancer	_____Who?	__Heart Disease	_____Who?	__Asthma	_____Who?
__Diabetes	_____Who?	__Alcoholism	_____Who?	__Stroke	_____Who?
__Arthritis	_____Who?	__Hypertension	_____Who?	_____Other	

Which of the following diseases have you had?

___mumps	___allergies	___gonorrhea	__Hepatitis C
___ear infections	___asthma	___genital herpes	__Tuberculosis
___measles	___oral thrush	___genital warts	__ARC
___chicken pox	___oral herpes	___chlamydia	__HIV +

SYMPTOM SURVEY

The following is a list of symptoms that you may or may not experience. Please indicate as follows:
leave blank if never experience, check mark (✔) if sometimes experience, plus sign (+) if always experience

__lack of appetite
__excessive appetite
__loose stool or diarrhea
__constipation
__difficulty digesting oily foods
__hemorrhoids
__vomiting
__abdominal pain
__digestive problems
__colitis or diverticulitis
__indigestion
__belching, burping
__recent use of antibiotics
__heartburn/reflux
__feeling retention of food in the stomach
__tendency to become obsessive or compulsive

__insomnia, difficulty sleeping
__heart palpitations
__cold hands and feet
__nightmares
__mentally restless
__laughing for no apparent reason
__angina pains
__anxiety attacks
__manic episodes
__poor memory
__difficulty concentrating
__frequent crying
__dry eyes
__dry hair
__dry skin
__dry mouth

__low back pain
__knee problems
__hearing impairment
__ear ringing
__kidney stones
__decreased sex drive
__increased sex drive
__hair loss
__urinary problems
__fearful
__pain or coldness in the genital area

__fatigue
__edema
__blood in stool
__black tarry stool
__easily bruised
__difficult to stop bleeding
__dizziness
__tendency to faint easily
__high cholesterol levels
__sudden weight loss
__sadness or grief
__thirsty
__prefer hot drinks
__prefer cold drinks
__thyroid disorders
__high blood pressure
__tremors
__chest pain
__sciatic pain

__cough
__shortness of breath
__decreased sense of smell
__nasal problems
__asthma
__allergies
__hay fever
__feelings of claustrophobia
__bronchitis
__tendency to catch colds easily
__intolerance to weather changes
__headaches

__eye problems
__jaundice
__gall stones
__light colored stools
__soft or brittle nails
__easily angered or agitated
__difficulty in making plans or making decisions
__spasms or twitching of muscles
__irritability
__breast lumps
__depression
__PMS

MUSCULOSKELETAL

Pain or numbness in any of the following areas
- for pain, please rate levels using a scale from 0-10, 0 is no pain and 10 is the worst.

___neck
___shoulders
___arms/elbows
___wrist/hands
___knees
___feet
___spinal stenosis
___scoliosis

___leg or calf cramping
___muscle weakness
___muscle spasms
___rheumatoid arthritis
___bursitis
___thighs
___legs
___calves

___poor posture
___sciatica
___low back pain
___swollen joints
___numbness in toes
___numbness in fingers
___degenerative joint disorder
___degenerative disc

What relieves your pain/condition?_____
Heat_____Cold_____Damp_____Weather_____Wind_____Medications_____Pressure____
What aggravates your pain/condition?_____
Heat_____Cold_____Damp_____Weather_____Wind_____Medications_____Pressure____

List any medications, vitamins, herbs, homeopathics and supplements you are currently taking:(continue on back if needed)

Medicine	Dosage	Reason	How Long

FOR WOMEN

Date of last period_____

Age of 1st period (menarche)_____
Age of last period (menopause)_____
Number of days between periods_____
Number of days of flow_____
Color of flow_____
Clots?_____Color_____
Do you use pads or tampons? (circle one or both)
Avg # per day Day 1_____Day 2_____Day 3_____
Day 4_____Day 5_____Day 6_____+Days_____

Cramps
Nature of your cramps and at what time of the cycle?
cramping_____stabbing_____
burning_____aching_____
dull_____bloating_____
consistent_____or intermittent_____
What relieves your cramping?_____

Are you pregnant?_____Trying?_____
# of pregnancies_____miscarriages_____
# of live births_____# of abortions_____
Date of last obgyn exam + results_____
Pap Smear_____Mammogram_____
Bone Density Scan_____

Other symptoms related to menses:
_____discharge_____vaginal dryness_____headache
_____nausea_____constipation_____swollen breasts
_____diarrhea_____ravenous appetite_____insomnia
_____hot flashes_____poor appetite_____↑libido
_____↓libido_____night sweats_____mood swings

Have you been diagnosed with (include year):
_____fibroids_____endometriosis_____PID
_____Ovarian cysts_____fibrocystic breasts

FOR MEN

Date of last prostate exam_____PSA results_____Manual prostate exam results_____
Frequency of urination: daytime_____nighttime_____color of urine_____odor_____

Symptoms related to prostate:
___prostate problems___delayed stream___dribbling___incontinence___retention of urine___impotence
___groin pain___testicular pain___premature ejaculation___back pain___dec. libido__Inc. libido___rectal dysfunction

Other_____
_____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including 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.

(Date)

PATIENT SIGNATURE **X**

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

(Date)

OFFICE SIGNATURE **X**

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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 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.

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:

(Date)

PATIENT SIGNATURE **X**

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

Bring this signed form with you for your initial office visit!