Dr. Zhou's Acupuncture and Wellness Clinic

Harmonizing Body Mind and Spirit

Name:	Phone (Work):	Phone (Cell):
Street:	Age: Birthdate:	
City:	Referred to us by:	
State: Zip:	Occupation:	
Primary Physician:	Emergency Contact:	Phone:
Main Concern:	Relationship:	
Other Current Therapies:	Email:	

Prior Medical History: (please include dates)

Significant Illness:

Cancer _____ Diabetes _____ High Blood Pressure _____ Heart Disease _____

Hepatits _____ Seizures _____ Rheumatic Fever _____ Thryroid Disease _____

Surgeries: Significant Trauma (auto accidents/falls):

Allergies (Drugs,chemicals,food): Occupational Stressors (chemical, physical, psychological):

Exercise (type): Times per week:

Average Diet (general)

Breakfast: Lunch: Dinner:

Habits:

Cigarettes _____ Coffee _____ Soda _____ Sugar _____

Salt _____ Drugs _____ Tea _____ other _____

Please list any history of family medical issues: (diabetes, cancer, HBP, heart disease, stroke, seizures, asthma, allergies, alcoholism, other) _____

GENERAL

o Poor Appetite	o Heavy Appetite	o Poor sleep	o Heavy sleep
o Insomnia	o Fatigue	o Tremors	o Vertigo
o Cold hands	o Cold Feet	o Cold back	o Cold Abdomen
o Fevers	o Chills	o Night Sweats	o Sweat easily
o Cravings	o Localized weekeness	o Poor coordination	o Change in appetite
o Sudden energy drop at _____		o Peculiar tastes/smells _____	
o Strong thirst (cold/hot drinks) _____		o Bleed or bruise easily (where) _____	

SKIN / HAIR

o Rashes	o Ulcerations	o Hives	o Itching
o Exzema	o Pimples	o Dandruff	o Loss of hair
o Change in hair/skin texture	o Pupura	o Other hair or skin problems _____	

HEAD, EYES, EARS, NOSE AND THROAT

o Dizziness	o Concussions	o Migraines	o Glasses
o Eye Strain	o Eye pain	o Poor vision	o Night blindness
o Color blindness	o Cataracts	o Blurry vision	o Earaches
o Ringing in ears	o Poor hearing	o Nose bleeds	o Sinus problems
o Mucus	o Dry throat	o Dry mouth	o Copius saliva
o Teeth problems	o Jaw clicks	o Grinding teeth	o Facial pain
o Gum problems	o Spots in eyes	o Recurrent sores _____ /Month	
o Sores on lips or tongue	o Headaches (where and when): _____		
o Other head or neck problems _____			

Last Revised 09/2014

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CARDIOVASCULAR

o High blood pressure o Low blood pressure o Chest pain o Irregular heartbeat
o Dizziness o Fainting o Cold hands/feet o Swelling in hands/feet
o Blood clots o Phlebitis o Difficult breathing o other

RESPIRATORY

o Cough o Coughing blood o Asthma o Bronchitis
o Pneumonia o Difficulty breathing when lying down o Tight chest
o Products of phlegm_____what color_____ o Other lung problems

GASTROINTESTINAL

o Nausea o Vomiting o Diarrhea o Bowel movements
0 Gas o Belching o Black stools _____Frequency
o Bad breath o Rectal pain o Hemorrhoids _____Color
o Constipation o Bloody stools o Senstivie abdomen _____Odor
o Pain or cramps o Laxative user_____/week; type_____ _____Texture/form

GENITO-URINARY

o Pain in urination o Frequent urination o Blood in urine o Urgency to urinate
o Unable to hold urine o Kidney stones o Venereal disease o Impotency
o Wake up to urinate How often_____/night; time_____ o Other G/U problems

PREGNANCY AND GYNECOLOGY

o Number of Pregnancies____Number of births____ o Prematur births o Miscarriages
o Age at first menses_____ o Period (days)___ o Last Pap____ o Irregular periods
o Typical flow (describe)_____ o Clots o Breast lumps o Menapause
o Birth control_____(type and duration) o Changes in body/psyche prior to menstration

MUSCULOSKELETAL

o Neck pain o Muscle pains o Back pain (where) o Joint pain (where)
o Other joing or bone problems _____ _____

NEUROPSYCHOLOGICAL

o Seizures o Areas of numbness o Poor memory o Concussion
o Depression o Anxiety o Bad temper o Easily stressed
o Treated for emotional problems o Considered/attempted suicide
o Other neruological or psychological problems

Comments

Body & Mind Balance

Free Health Assessment

Full Name: _____ ***Cell Phone:*** _____

(Please Print) ***Email:*** _____

Rate the following 1-5: 1-2 *(Mild)* ***3*** *(Moderate)* ***4-5*** *(Severe/Chronic) X appropriate box*

(Body)	1	2	3	4	5
Headaches/Migraines					
Pain in Joints/Arthritis					
Back Pain / Hip Pain					
Fatigue					
Cold Hands/Feet					
Muscle Pain/ Numb/ Cramping					
Limited Motion/Exercise					
Neck Pain / Shoulder Pain					
Hand/Elbow/Wrist Pain					
Digestion/Acid Reflux					
Diarrhea / Incontinence					
Foot Pain					
Eczema/Skin Problems					
Allergies/Sinus					
Over Weight					
Infertility/Libido					
Edema (Swelling)					
Asthma/Lung problem					
Chest Pain/ Palpitation					
Hormone Imbalance					
Total points:					

**Subtract total Points From 100*

Body Total _____/100

(Mind)	1	2	3	4	5
Anxiety/Nervousness					
High Stress					
Low Productivity					
Irritability/ Impatience					
Depression					
Low Motivation					
Fear					
Over Eating					
Insomnia/Poor Sleep					
Foggy Brain					
Grief/Sadness					
Indecisiveness					
Cravings					
Bipolar Disorder					
Difficulty Concentrating					
Obsessive Compulsive Disorder					
Restlessness					
ADD/ADHD					
Poor Attitude					
Alcohol or Drug Usage					
Total points:					

**Subtract total Points From 100*

Mind Total____/100

Health Risks (-10 Pts.)	
> 3 Medications	
Hospitalized in Last 12m	
Smoking	
Pacemaker	
High Blood Pressure	
Diabetes	
Cancer	
Cardiovascular Disease	
Other:	

Health Benefits (+5 Pts.)	
Excersise Over 3x Per Week.	
Take Daily Suppliments/Herbs	
Other:	

1 **Body + Mind** ____ **÷2 =**_____

2 **Subtract** Risks Total: -_____

3 **Add** Benefits Total: + _____ =

Total Wellness Score

_____***/100***

Please Sign

Signature:_____ Date:_____

Office Initials:_____

Policies, Consent and Records or Release Authorization

Payment:

I understand that payment is always due the same day of the treatment/services rendered. Cash, check or credit cards are all acceptable forms of payment. If you have insurance that may or may not cover treatment, payment is still due at time of service. We will provide you with any necessary information for you to fill your claim.

Insurance:

If you are a member of an insurance company we have any form of contract with, you are responsible for the co-payment, or a certain amount of the down-payment at the time of service. You are aware that if the insurance claim is not paid in full or is denied, you are responsible to pay the remaining portion of the bill within 6o days after the service.

Cancellation:

I understand that if I need to cancel an appoinment, I will give at least a 24-hour's notice, unless of an emergency. If I cancel last minute or do not call to cancel my scheduled appointment, a fee of $50 will be owed and added to your next charge.

Confidentiality:

At Dr. Zhou's Acupuncture and Wellness Clinic (American Alternative Healthcare), we are commited to protecting your privacyy and the confidentiality of your medical records. To this end, we have designed a comprehensive program within both of our clinics. Clinicians, interns and all other personnel have been sufficiently trained and sensitized to not only the state and federal requirements, but the ethical handling of your personal information.

Interns, Clinicians and all other personnel:

I have been informed that this is an educational facility as well as a health care clinic. Therefore. I may encounter the assistance of student interns in the clinic. I am aware that their role as clinic personnel is to assist in the removal of needles and to perform the massage in which they are being trained to do.

Reimbursement:

I am aware that initial visits and individually pain treatments are non-refundable. Discounted packages will be reimbursed at the standare rates of $110 or $85, depending on package you originally purchased. If there is a balance from an insurance payment, the difference will be refunded to you.

Release of Records:

Your medical record is the physical property of AAHC, however, the information contained in the records belongs to you and will only be released to other professionals with your written consent. You have the right to-

* Review and requst a copy of the information used to design and carry out your treatment.
* Ask us to amend the information which you feel is wrong or incorrect.
* Ask us to restrict the information we share about you.
* Ask us to communicate with you in a certain way or place.
* Request a list of who has recived your records.

By voluntarlily signing below, I show that I have read, or have read to me, the above policies, consent, and release information and have had an opportunity to ask any questions. I intend for 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 Signature: _____ Date: _____

(or patient represenative)

Office Signature: _____ Date: _____

(updated September 2014)

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 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 (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 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. 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.

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.

(Date)

PATIENT SIGNATURE **X**

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

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 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, 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 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.

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 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 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 SIGNATURE	**X**	(Date)
(Or Patient Representative)		(Indicate relationship if signing for patient)
OFFICE SIGNATURE	**X**	(Date)

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE