Health Questionnaire

Your answers to the following questions will help us to understand your medical history and the concerns you would like to discuss with your practitioner. Please complete as much of this questionnaire as possible. If you cannot answer some of the questions or if you feel uncomfortable answering them, leave them blank. Thank you for your assistance.

PATIENT NAME: _____

DATE OF BIRTH: _____ **TODAY'S DATE:** _____

FULL ADDRESS: _____

_____

PHONE NUMBER: _____ **EMAIL:** _____

OCCUPATION: _____

What health issues would you like help with now? _____

_____

Health Questionnaire

MEDICAL HISTORY

Please check to indicate if you have ever had the following conditions:

ADD/ADHD	Coronary Artery Disease	Liver Disease
Allergies (environmental)	Depression	Musculoskeletal Issues
Alzheimer's	Diabetes	Multiple Sclerosis
Anemia	Eczema/Psoriasis	Sciatica
Asthma	Heartburn/Reflux	Scoliosis
Autoimmune Disorder	Hepatitis	Seizures
Blood Clot	High Blood Pressure	Sleep Apnea
Bowel Issues (IBS, Crohn's)	High Cholesterol	Thyroid Disease
Cancer	HIV/AIDS	Ulcers
Congestive Heart Failure	Insomnia	
COPD	Kidney Disease	

Please list any surgeries or hospital stays you have had and their approximate date/year:

Type of surgery/reason for hospitalization *Date*

_____ _____

_____ _____

_____ _____

Please list any serious medical issues, illnesses, or injuries not listed above:

_____

_____

When was your last physical? _____

Do you take any medications? ☐ Yes ☐ No

If yes, please specify _____

_____

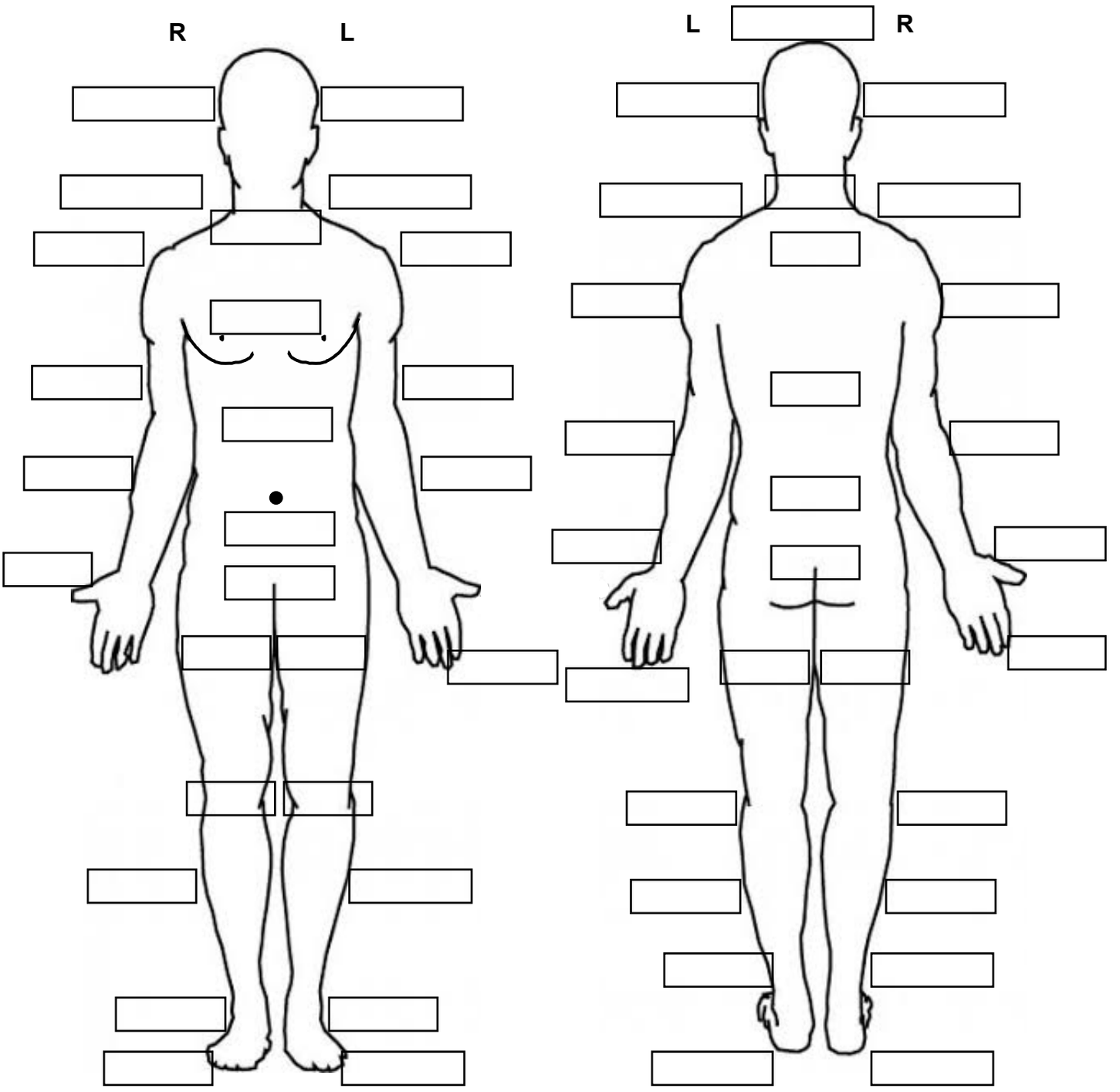
Have you gotten Covid-19 vaccinations? ☐ Yes ☐ No

Have you been exposed to Covid-19? ☐ Yes ☐ No

Health Questionnaire

Please mark the areas where you feel pain in your body. Write the following letters next to the areas you check to describe the type of pain you experience. You can use more than one letter:

S = stabbing pain	**C = constant**
R = radiating pain	**B = burning**
N = numbness	**I = intermittent**
D = dull ache	



Health Questionnaire

Are you currently receiving care from any other physicians, chiropractors, or other health care professionals?

Provider's Name	*Condition for which you are seeking treatment*

If you have had any of the following tests, note approximate date and the results, if known.

Test	Approximate Date	Result
Cholesterol		
Colonoscopy		
Hepatitis C		
HIV		
Mammogram		
Pap smear/pelvic		
Prostate Exam		

Please list any known allergies to food or drugs: _____

_____

Activity Level (check one)

Sedentary (inactive) due to inability/restriction
Light daily work w/no exercise
Light daily work & exercise 3x/week
Moderate daily work & exercise 3x/week
Moderate daily work and exercise 5x/week
Sedentary (inactive) by choice

Stressors in Your Life (check all that apply)

Difficulties with work or lifestyle
Dysfunctional family: Past Now
Death or serious illness of family or friend
Relationship issues
Lack of love or fulfilling relationships
Illness (self)

Health Questionnaire

WOMEN ONLY

Have you ever been pregnant? Yes No

How many times? _____

How many miscarriages? _____

How many abortions? _____

How many children do you have living? _____

Do you have menstrual periods? Yes No

If yes, how long is your cycle? _____

If no, at what age did they stop? _____

Do you use any form of birth control? Yes No

If yes, what type? _____

FAMILY HISTORY

Use a check ( ) to indicate diseases/disorders that run in your family:

	None	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Child	Other (Please explain)
Alcohol or Drug Issues											
Cancer											
Heart Disease											
High Blood Pressure											
High Cholesterol											
Neurological Disorder											
Stroke											
Thyroid Disease											
Age at Death											
Other:											

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 proceeings. 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 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 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.

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

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the perfomance 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 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.

ACUPUNTURIST NAME:

PATIENT SIGNATURE **X** (Date)

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

ALSO **SIGN** THE **ARBITRATION AGREEMENT** ON **REVERSE** SIDE