CONFIDENTIAL

Today's Date:__________

Dr. Tracy Ng, L.Ac., DAOM

2510 Main Street, Suite 209
Santa Monica, CA 90405
Tel 310.393-3012
Fax 310.745.0659
Email: tracy.ng@mac.com

PATIENT BILLING AND CONTACT INFORMATION

NAME____

IF PATIENT IS A MINOR, PARENT'S NAMES____

BIRTHDATE______________________AGE_________SEX_________MARITAL STATUS____

MAILING ADDRESS____

____

HOME PHONE (_______)_________________________WORK PHONE (_______)___________

CELL PHONE (_______)_________________________FAX NUMBER (______)___________

EMAIL ADDRESS ____

OCCUPATION____

EMPLOYED BY____

SUPERVISOR NAME____

EMPLOYER ADDRESS____

EMPLOYER PHONE____

WHO IS RESPONSIBLE FOR PAYMENT ON THIS ACCOUNT?___________________________

WHERE SHOULD BILLS BE SENT?

NAME____

ADDRESS____

PHONE NUMBER____

WHO MAY WE THANK FOR YOUR REFERRAL?____________________________________

IN CASE OF EMERGENCY, WHO MAY WE CONTACT?

NAME_________________________________PHONE NUMBER ____________________

RELATIONSHIP____

Tracy Ng, L.Ac., DAOM
2510 Main Street, Suite #209
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tracy.ng@mac.com

OFFICE POLICIES AND FINANCIAL AGREEMENT

The fees for office services, supplements and support are payable in full at the time of your visit, unless other arrangements have been made. The fees charged in this office are comparable to those charged by other specialists with similar qualifications in this area.

If it is necessary for you to cancel or reschedule an appointment, we require a FULL 24 HOURS NOTICE to change your appointment without charge. *Any appointments canceled or rescheduled without 24 hours notice will be charged for a full office visit.* Please realize that we have reserved this time for you and that another person in need of care will be able to have time with the doctor when 24 hours notice is given. Please note that if you are more than 20 minutes late for your appointment, we may not be able to accommodate you.

Please understand that we have no payment agreements with your insurance companies. Insurance benefits are a matter between you and your insurance company. We will be happy to supply you with any information you may need to assist you in procuring payment of your medical claims. Submission of medical insurance claims is the responsibility of the insured.

If you are a patient who has had a non-work related accident, automobile, or other injury, it is your responsibility to provide us with the name and address of both the responsible insurance companies and that of your attorney.

We reserve the right to make a finance charge at an interest rate of 1.5% per month for every month that your account remains overdue after 30 days.

I have read, understand, and agree to the above policies.

Name (Print)____

If patient is a minor, name of child for whom I am the parent or legal guardian________________________

Signature____Date__________________

INFORMED CONSENT

Tracy Ng, L.Ac., DAOM is a Licensed Acupuncturist and Doctor of Oriental Medicine. Dr. Ng is not a medical doctor. She does not claim to diagnose, treat, cure, or prevent any medical conditions or pathologies, nor prescribe medicine, nor in any way represent herself as doing so. The services of a Doctor of Oriental Medicine cannot replace those of a licensed physician. For any medical condition, you are advised to seek care from an appropriate medical practitioner. It is your right whether you choose to engage a medical practitioner or not to assist you in your care, and Dr. Ng assumes no responsibility for your decision in this matter.

I, the undersigned, assume all responsibility for decisions I make regarding my health, recognizing that (a) no claims are made that acupuncture, herbal, nutritional, or dietary recommendations can treat or cure any medical condition, (b) all recommendations are given for informational purposes only, (c) there is no implied or stated guarantee of success of effectiveness of any specific acupuncture, dietary, nutritional, or herbal recommendations, (d) I am free to act upon or disregard the recommendations of Tracy Ng, L.Ac., DAOM. as I so choose. I hereby release Dr. Tracy Ng and the Office of Tracy Ng, D.A.O.M. from all responsibility for my actions and any consequences thereof in the present time and in the future with no constraints. I hereby affirm that I consent and agree to the above statements of my own free will and request to engage in the services offered by Tracy Ng, L.Ac., DAOM and participate in a professional relationship with her pursuant to the statements herein.
Name (Print)____

If patient is a minor, name of child for whom I am the parent or legal guardian________________________

Signature____Date__________________

NOTICE OF PRIVACY PRACTICES

TRACY NG, L.AC., DAOM
2510 MAIN STREET, SUITE #209
SANTA MONICA, CA 90405
310.393.3012

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

a. Keep your medical information private
b. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information
c. Follow the terms of the current notice.

We have the right to:

a. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
b. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices

d. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.
e.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we may use and disclose medical information. Not every use or disclosure will be listed. However, <u>we have listed all the different ways we are permitted to use and disclose medical information.</u> <u>We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.</u>

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses, and credentials we need to serve you.

Additional Uses and Disclosures: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

Notification: We may use and disclose medical information to notify or help notify a family member, your personal representative, or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray, or medical information for you.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.
Pubic Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs, or replacements, to track products or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.
Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a personal who has admitted to being part of a crime or has escaped from legal custody.
Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.
Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.
Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

a. Look at or get copies of certain parts or your medical information. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $__.20__ for each page, and postage if you want the copies mailed to you.
b. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
c. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency.)
d. Request that we communicate with you about your medical information by different means or to different locations. Your request must be made in writing to the contact person listed at the end of this notice.
e. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
f. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.
g.

QUESTION AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

Tracy Ng, L.Ac., DAOM
2510 Main Street, Suite #209
Santa Monica, CA 90405

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

PRIVACY PRACTICES ACKNOLWEDGEMENT

I have received or have been provided an opportunity to review a copy of the Notice of Privacy Practices.

______________________________ ______________________________ ______________

Name Signature Date

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Telephone ___________________________
  - ☐ O.K. to leave message for appointment reminder calls
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Work Telephone ___________________________
  - ☐ O.K. to leave message for appointment reminder calls
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Written Communication
  - ☐ O.K. to mail to my home address
  - ☐ O.K. to mail to my work/office address
  - ☐ O.K. to fax to this number____
- ☐ Email____

____ ______________

Patient Signature Date

____ ______________

Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.
Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures may be permitted without prior consent in an emergency

STOP HERE

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom, Address or Fax Number	Purpose of Disclosure	By Whom Disclosed	T=Tx Records P=Payment Info	F=Fax E=Email M=Mail

CONFIDENTIAL MEDICAL HISTORY

DATE____________

NAME____AGE_________________M______F

DATE OF BIRTH_____________________MARITAL STATUS_______Height___________Weight___________

Name of Family Physician____

Occupation____Referred by__________________________________

INSTRUCTIONS: In order to carefully evaluate your condition(s) and acquire a thorough overview of you as a unique individual, please take the time to thoughtfully complete this extensive questionnaire, so that an individualized treatment plan can be developed.

PRIMARY REASON(S) AND GOAL(S) FOR YOUR VISIT AND TREATMENT?

____

____

Have you previously been treated by: _____Acupuncture _____Herbal Medicine _____Nutritional Therapy _____Homeopathy ______Chiropractic? Name(s) of Practitioners____

FAMILY HISTORY	Self	Mother	Father	Brother	Sister	Grand-parents	Comments
Alive? (Yes/No)	Y						
In Good Health? (Y/N)							
Arthritis/Gout							
Asthma							
Allergies							
Cancer (what type?)							
Diabetes							
Epilepsy/Seizures							
Heart Disease							
Hepatitis A,B,C, other							
High Blood Pressure							
Thyroid Disease							
Kidney Disease							
Emotional Disorders							
Stroke							
Ulcers							
Tuberculosis							
Bleeding Disorders							
Weight Problems							

PLEASE CHECK ANY OTHER ILLNESS WHICH YOU HAVE HAD

___Anemia
___eczema
___Psoriasis
___Bronchitis
___Emphysema
___Diverticulitis
___Colitis
___Hepatitis
___Hernia
___Fibromyalgia

___Eye disease
___Gall stones
___Malaria
___Liver disease
___Typhoid fever
___Yeast infection
___Jaundice
___Pancreatitis
___Migraines
___Epstein Barr Virus

___Mononucleosis
___Polio
___Rheumatic fever
___Chicken pox
___Measles
___Mumps
___Hemorrhoids
___Parasites
___Chronic fatigue syndrome

Sexually transmitted diseases
___Herpes
___Gonorrhea
___Syphilis
___HIV
___Genital Warts, HPV
___Other

DIAGNOSTIC TESTS, PLEASE NOTE YEAR IF KNOWN

X-Ray/Ultrasound	CT-Scan/MRI	___Mammogram
___Chest	___Brain	___Bone Density(osteoporosis screen)
___Kidney	___Bone	___PAP Smear
___Upper G.I.	___Spine	
___Lower G.I.		___Prostate Exam
___Gallbladder	___EKG electrocardiogram	___Blood Profile
___Sinus	___EEG electroencephalogram	___Urine Test
___Bone	___TB Skin Test	___Hearing Test
___Spine	___Thyroid Tests/Exam	___Eye Exam

Please name physicians and practitioners you are currently seeing or have seen in the past two years

Name *Reason for visit* *Date or Age*

Please list past major illnesses, accidents, injuries, surgeries, and hospitalizations Date or Age

Current Prescriptions or Over-the Counter Medications

Past use of antibiotics or steroids (prednisone, cortisone, etc.):

Current Vitamins, Herbal, Homeopathic and Natural Medicines

Are you now or have you ever taken any of the below?

___Birth Control Pills	___Sedatives or Sleeping Pills	___Pain Medication
___Estrogen or Progesterone	___Thyroid Medication	___Chemotherapy
___Cortisone or other Steroids	___Allergy Shots	___Blood Pressure Medication
___Anti-depressant Medication	___Antihistamines	___Cholesterol Medication
___Anti-anxiety Medication	___Antibiotics	___Other

PLEASE LIST ANY KNOWN ALLERGIES (food, drugs, pollens, dust, etc.)

___

LIFESTYLE

Do you currently smoke cigarettes?___________ Do you want to quit?__________________________
Have you ever smoked cigarettes?____________ For how long?______________ Packs per day________
Recreational drug use__________________past____________present History of IV use ___yes ____no
Do you drink alcohol?________How often?________________Type?____________________________
Do you drink ________coffee________black tea_____________decaf_________regular Cups per day
Amount of time spent outside daily_________________Hours per day on sitting or on computer_______
How often do you exercise?_______________________Type of exercise_________________________
What do you do to unwind and relax?___________________________________How often?__________
Meditation______Yoga______Martial Arts______Cardiovascular exercise______Weight training_____.
Stretching_____

DIET & FOOD **Please check all that apply**

___Weight Fluctuations ___Overeating ___Frequent Dieting ___Vomit after eating
___Anorexia ___Bulimia ___Food Binges ___Use of diet pills/ appetite suppressants
___Satisfied ___Dissatisfied with current bodyweight

What do you usually eat for:

Breakfast____

Lunch____

Dinner____

Snack____

Do you typically ____eat out____eat home cooked meals?

Are you on a special diet? Why? Describe____________________________________

CRAVINGS (please mark C) or Food Aversions (please mark A)

___Salty ___Sour ___Starches ___Spicy ___Oily/Fatty
___Milk/Dairy ___Sweets ___Breads/Pastas ___Chocolate ___Eggs
___Iced/cold foods ___Warm Foods ___Other

SYMPTOMS: Please circle any that have bothered you in the past 6 months. Please comment if you have noticed timing of onset, frequency, duration, patterns, etc.

HEAD

Headaches Sore scalp/dandruff Dizziness Hair loss

EYES

Dry eyes Inflamed eyes Swelling or pain Dark circles
Excessive tearing Double vision Eyeglasses Puffiness
Light sensitivity Blurred vision Contact lenses Eye surgery
Ear pain Ear ringing Ear discharge Dizziness
Poor hearing Deafness Loss of Balance

NOSE

Poor sense of smell	Post nasal drip	Sensitivity to:	
Frequent colds/flus	Frequent bloody nose	Dust	Animal hair
Hay fever/Allergies	Sinus pain	Molds	Chemical fumes
Sinus Infection	Sores in Nose	Pollens	Pesticides
Nasal obstruction	Runny nose	Perfumes	

MOUTH

Bleeding gums	Oral herpes (Cold Sores)	Dental cavities	Ulcers in mouth
Dry lips	Dry mouth	Dentures	Sore tongue

THIRST

Normal thirst   Rarely Thirsty   Excessive Thirst

Please check drink preference ___HotCold ___Iced___Room Temperature

RESPIRATORY

Sore throat	Spitting up mucus often	Bronchitis	Blood in sputum
Difficulty swallowing	Hoarseness	Thick sputum	Pain with breathing
Tonsillitis	Cough	Wheezing	Shortness of breath

Sensation of something is caught in throat

CARDIOVASCULAR

Chest pain	Leg cramps at night	Cold hands or feet	Shortness of breath
Tightness in chest	Leg cramps when walking	Heart attack	Swollen ankles/feet
Heart palpitations	Bruise or bleed easily	Stroke	Heart murmur
Difficulty lying flat	Varicose veins	High cholesterol	Mitral valve prolapse
Rheumatic fever	Wounds infected easily or heal slowly	Irregular heart beat	

SKIN

Rash	Itching	Herpes	Warts
Pigment changes	Abnormal sweating	Acne with stress	Skin or nail fungus
Dryness	Eczema	Acne with menstruation	Psoriasis

GASTROINTESTINAL

Poor appetite	Poor digestion	Food allergies	Spit up blood
Pain with eating	Nausea	Belching	Hypoglycemia
Excessive appetite	Heartburn	Ulcers	Difficulty swallowing
Intestinal gas/bloating	Vomiting	Sleepy after eating	Gallbladder problems
Diarrhea	Loose or watery stool	Undigested food in stool	Black or tarry stools
Constipation	Dry hard stool	Blood in stool	Hemorrhoids
Mucus in stool	Hernia	Use laxatives often	Inflammatory bowel disease

How often do you have a bowel movement?________________________

URINARY

Frequent bladder infections___with intercourse___with stress

Frequent urination	Loss of force of urine stream	Pus in urine
Urge to urinate at night	Pain or burning with urination	Blood in urine
Urination with cough or sneeze	Retention of water/fluids	Sand/gravel in urine
Hesitancy of urination	Hands or ankles swell easily	Change in quantity of urine

Color of Urine: ___clear___straw___yellow other__________________How often do you urinate each day?

REPRODUCTIVE

Decreased sexual desire	HIV	Infertility	Sexual Orientation:
Gonorrhea	Trichomonads	Celibate	Heterosexual
Herpes	Chlamydia	Multiple Sexual Partners	Gay/Lesbian
Syphilis	Genital Warts (HPV)		Bisexual

MEN ONLY

Burning or Discharge from Penis	Anal Sex	Seminal Emission
Low Sperm Count	Male Sexual Partners	Premature Ejaculation
Prostate Surgery	Prostate Infection	Pain or Coldness in Genital Area
Prostate Inflammation	Prostate Enlargement	Swelling or Lumps in Testicles

Difficulty in Achieving or Maintaining an Erection

Method of Birth Control_________________________________

Frequency of Intercourse____

Date of Last Prostate Exam______________________________________

Have you had a PSA test (blood test screen for prostate cancer)?______________Date_________

WOMEN ONLY

Vaginal Pain	Vaginal Sores	Infertility	Discharge from Nipples
Vaginal Dryness	Vaginal Itching	Ovarian Cysts	Breast Lumps or Cysts
Vaginal Discharge	Pelvic Infection	Uterine Fibroids	Breast Tenderness
Vaginal Infections	Painful Intercourse	Endometriosis	

Frequency of Intercourse?________________________________

Do you practice regular breast self exam?__________________________

Date of last mammogram_______________________________________

Date of last PAP test and pelvic exam______________________

Personal or Family history of Cancer? ____Breast____________Ovarian_______Cervical

Menstruation & Pregnancy

No Menstrual Period	Premenstrual Bloating	Heavy Blood Flow	Light Blood Flow
Irregular Periods	Menstrual Cramps/Pain	Clots in Blood	Spotting Between Period

If you have Premenstrual Syndrome, please describe _________________________________

____

Age of first period____________How many days apart are your periods?______________

How many days do you flow?_________

Number of pregnancies_____Number of abortion_____Number of miscarriages ________

Number of live births________________Are you or might you be Pregnant?___________

Fertility treatment? Describe____

____

Cesarean Section?____________Complications with pregnancy, labor, or delivery?____________

____

Birth Control Method. Current____________________________Past_______________________

Menopause

Age or year when menstrual cycles ceased____________

Currently Menstruating?_____________How Often?__________Changes in cycle_____________

Hormone Replacement Therapy?_________Drugs or Herbal Medicines______________________

Hot Flashes__________Night Sweats_________Change in Sex Drive_______________________

Change in Mood? Describe________________________________Change in Sleep?____________

___________________________Other_____________________________

Have you had a bone density scan (for osteoporosis)?_____Date________Results______________

____

ENDOCRINE/IMMUNOLOGIC

Diabetes	Hypoglycemia	Infertility	Fatigue
Abnormal Weight Gain	Abnormal Weight Loss	Night Sweats	Unexplained fever or chills
Frequent Low Grade Fever	Loss of feeling of well-being	Depression	
Neck Enlargement	Hair or Nail Changes	Intolerance ___to heat ___to cold ____to wind	
Dry Skin	Fluid Retention	Perspiration ____excessive ____diminished	

MUSCULOSKELETAL

Arthritis Muscle Spasm Swelling Stiffness Sciatica Disc Injury Scoliosis Osteoporosis

Check Location of Pain Below/ Describe____

____

___Foot ___Ankle ___Knee ___Leg ___Hip ___Shoulder ___Elbow ___Wrist ___Arm ___Hand
___Head ___Neck ___Spine ___Jaw Other____.

NEUROLOGIC

Nervousness	Shaking seizures	Drowsiness	Loss of sensation
Dizziness	Convulsions	Memory changes	Changes in handwriting
Numbness	Loss of coordination	Fainting	Nerve pain
Tremors	Paralysis	Muscular weakness	

SLEEP

Insomnia	Difficulty Staying Asleep	Wake up Often at Night/At What Time?
Difficulty Falling Asleep	Disturbing Dreams/Nightmares	

Position you sleep in________________Usual Bedtime_______________ Usual Waking Time_________

WORK

Type of work/profession___________________________________Number of hours worked daily_________
I spend much of the day ___Sitting ___Standing ___Lifting ___On the Phone ___Heavy Physical Work

I find my work ___Fulfilling ___Enjoyable ___Boring ___Frustrating ___Stressful ___Exhausting

STRESS/EMOTIONS

What are the sources of stress in your life now?____
My ability to cope with stress is _______Poor _______Fair _______Good _______Excellent
I am under the care of a ____Psychotherapist____Psychiatrist
I am currently taking medication for___mood___sleep___pain

Please note those feelings that describe your tones, qualities, tendencies and experiences in the last 12 months.

Frequent stress	Loss of mental clarity	Relaxed	Death of a loved one
Mood swings	Feeling hostile	Fulfilled	Spiritual
Loss of well-being	Unusual tension	Content	Religious
Listless/lethargic	Angry outbursts	Optimistic	Philosophical
Undue fatigue	Frustrated	Motivated	Introspective
Difficulty with decisions	Irritable	Inspired	Expressive
Withdrawn	Frequent crying	Joyful	Tend to be social
Lonely/isolated	Sadness	Daytime sleepiness	Tend to be a loner
Nervous/anxious	Despair	Disturbing dreams	Alcoholism
Overwhelmed	Grief/loss/sorrow	Insomnia	Substance abuse
Pressured	Disappointment	Worried by little things	Eating disorder
Conflicted	Hopelessness	Perfectionist	Weight problems
Shaky	Depression	High achiever	Comfortable with myself

Fragile	Suicidal thoughts	Very sensitive	
Easily offended	Self-critical	Change in marital status	
Poor concentration	Critical of others	Change in residence	
Memory Changes	Unhappy	Change in work/job	

TOXIC EXPOSURES **Please Circle All that Apply.**

Lead	Radiation	Tobacco	Asbestos	Chemical Fumes	Chemotherapy
Uranium	Pesticides	Herbicides	Mercury(silver-mercury dental fillings)		Other

TIME OF DAY/CLIMACTIC FACTORS

What hour(s) of the day do you feel at your best?____________________AM _____________PM

At your worst?____________________AM _____________PM

Please specify (B) for Better or (W) for Worse

Season/months of the year ____Spring____Summer ____Fall ____Winter

Do you feel Better or Worse ____Work ____Home ____Inside ____Outdoors

Climate: Better or Worse ____Dry ____Hot Cold ____Snow ____Damp ____Rain

List the health issues that concern you most, in order of importance

1,____2.____

3.____4.____

In your opinion, what are the primary factors contributing to the onset and continuation of your illness or loss of well-being?____

____

What do you feel will help you to achieve your goals? How long do you expect the process to take?

____

____

Thank you for taking the time to fill out this questionnaire. Your answers will allow for the development of a unique treatment plan not only for symptomatic treatment, but also for holistic healing.

Health is more than the absence of disease. Health is conscious living focused on wellness of the mind, spirit, and body.

PATIENT NAME

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 1 OF 2 - PLEASE SIGN BOTH SIDES

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 California 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 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 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)

PLEASE SIGN REVERSE SIDE ALSO

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 2 OF 2 - PLEASE SIGN BOTH SIDES

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 effect 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.

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

PLEASE SIGN REVERSE SIDE ALSO