



welcome.

Last Name _____ First Name _____
Address _____ Home Phone _____
City _____ State _____ Zip _____ Work Phone _____
Email _____ Cellular Phone _____

How did you hear about us? _____
Sex ____male ____female Age ____ Date of Birth _____
Marital Status ____single ____married ____divorced ____widowed
Diagnosis by Your Doctor (if any) _____
Patient Complaint _____

Medical Condition

Do you have any type of heart problem? ____yes ____no
If yes, please specify, _____

Do you have high blood pressure? ____yes ____no
Do you have Diabetes? ____yes ____no
Do you have Hepatitis? ____yes ____no
Are you HIV Positive? ____yes ____no
Have you ever had any type of surgery? ____yes ____no
If yes, please specify, _____

If female, are you pregnant? ____yes ____no
____Number of children ____Number of miscarriages
Have you ever had an Acupuncture treatment? ____yes ____no

Please list all medications and/or supplements you are currently taking and the reason.



wellness spa

Personal Condition

Sleeping ___normal ___insomnia ___excessive ___multiple dreams
Appetite ___normal ___poor ___excessive ___vegetarian
Digestion ___normal ___poor
Throat ___normal ___dry ___dry mouth ___bitter taste
Bowel ___normal ___diarrhea ___gas ___constipated
Urine ___normal ___excessive ___incontinence
Expectoration ___none ___some ___heavy If yes, ___white ___yellow
Chill ___normal ___cold If yes, ___hands ___feet ___back ___stomach
Women: Menstruation ___normal ___irregular ___none ___heavy
Women: Female Discharge ___none ___yes If yes, ___white ___yellow ___blood ___smell

Daily Habits

Do you drink coffee regularly? ___yes ___no If yes, ___1-2/day ___3-4/day ___5+/day
Do you drink alcohol regularly? ___yes ___no If yes, how often? ___
Do you smoke cigarettes daily? ___yes ___no If yes, how many? ___

Family Health History

Maternal History

Mother ___alive ___deceased Reason for death ___
Grandmother ___alive ___deceased Reason for death ___
Grandfather ___alive ___deceased Reason for death ___

Paternal History

Father ___alive ___deceased Reason for death ___
Grandmother ___alive ___deceased Reason for death ___
Grandfather ___alive ___deceased Reason for death ___

Consent for Acupuncture and Herbal Medicine

I, the undersigned, acknowledge that Acupuncture may be considered as an investigative procedure in the United States. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

patient signature _____ date _____
(Or Patient Representative - Indicate relationship if signing for patient)

Arbitration Agreement and Informed Consent, Page 1 of 2 – please sign both pages

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 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 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 of notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal stature 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 thirty 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 the 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

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

date

office signature

date

Arbitration Agreement and Informed Consent, Page 2 of 2 – please sign both pages

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 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 my treatment for my present condition and for any future condition(s) for which I seek treatment.

patient signature

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

date

office signature

date

Patient Information and Consent

(Please read this information carefully and ask your practitioner if there is anything that you do not understand.)

What is Acupuncture?

Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body.

Is Acupuncture Safe?

Acupuncture is generally very safe. Serious side effects are rare – less than one per 10,000 treatments.

Does Acupuncture Have Side Effects?

You need to be aware that:

- Drowsiness occurs after treatment in a small number of patients and, if affected, you are advised not to drive.
- Minor bleeding or bruising occurs after acupuncture in about 3% of treatments.
- Pain during treatment occurs in about 1% of treatments.
- Symptoms can get worse after treatment (less than 3% of patients). You should tell you acupuncturist about this, but it is usually a good sign.
- Fainting can occur in certain patients, particularly at the first treatment.

In addition, if there are particular risks that apply in your case, your practitioner will discuss these with you.

Is There Anything Your Practitioner Needs to Know?

Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced a seizure, dizziness, or fainting episode
- If you have a pacemaker or any other electrical implants
- If you have a bleeding disorder
- If you are taking anti-coagulants or any other medications
- If you have damaged heart valves or have any other particular risk of infection

SINGLE-USE, STERILE, DISPOSABLE NEEDLES ARE USED IN THE CLINIC.

Statement of Consent

I confirm that I have read and understood the above information and I consent to having acupuncture treatment. I understand that I can refuse treatment at any time.

patient signature

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

date

Pediatric Consent for Acupuncture – if patient under the age of 18

I, being the parent or legal guardian of _____, hereby consent to my son/daughter receiving Acupuncture by Village Health Georgia, P.C., doing business as Village Health Wellness Spa. I understand and acknowledge that Acupuncture may be considered as an investigative procedure in the United States. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

parent/guardian signature

date

print name

relationship to patient