

# acupuncture profile & release form

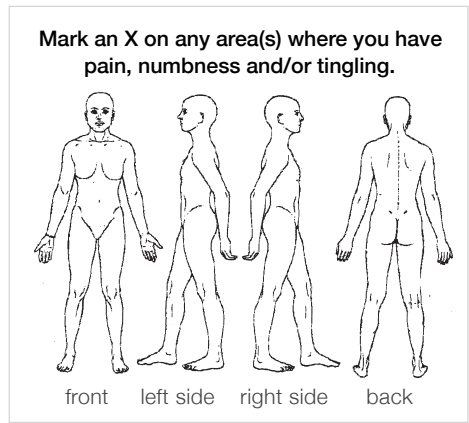
## Patient Information

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Email \_\_\_\_\_ Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year  
 Height \_\_\_\_\_ Ft. \_\_\_\_\_ In. Weight \_\_\_\_\_ Lbs. Marital Status  Single  Married  Partnered  Separated  Divorced  Widowed  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 How did you hear about us? \_\_\_\_\_ Email me monthly exclusive spa specials  Yes  No

## Patient Condition

Reason for Visit \_\_\_\_\_  
 Has this condition been diagnosed by a physician or other provider?  Yes  No  
 If yes, diagnoses \_\_\_\_\_  
 Are you being treated for this condition by anyone else?  Yes  No If yes, describe \_\_\_\_\_  
 Have these treatments helped?  Yes  Somewhat  Not Much  Not At All  
 How does this condition affect you? \_\_\_\_\_  
 How long have you had this condition? \_\_\_\_\_

**Please answer the following questions if you have pain:**  
 Is the condition getting progressively worse?  Yes  No  Unknown  
 Rate the severity of your pain (0=no pain to 10=severe pain) \_\_\_\_\_  
 Type of pain:  Sharp  Burning  Throbbing  Numbness  Aching  Swelling  Dull  
 Tingling  Stabbing  Shooting  Stiffness  Other \_\_\_\_\_  
 How often do you have this pain? \_\_\_\_\_  
 Describe your pain:  Constant  Comes and Goes  Other \_\_\_\_\_  
 Activities/Movements painful to perform:  Sitting  Standing  Lying Down  
 Walking  Bending  Other \_\_\_\_\_



## Health History

Do you have seizures?  Yes  No  
 Do you have high blood pressure?  Yes  No  
 Do you have Diabetes?  Yes  No  
 Do you have an infectious disease?  Yes  No  Possibly  
 If yes, please identify:  HIV/AIDS  Hepatitis B  Hepatitis C  Flu/Cold  Streptococcus  Mononucleosis  Tuberculosis  
 Other \_\_\_\_\_  
 Do you have any type of heart problem?  Yes  No If yes, specify \_\_\_\_\_  
 Do you have any known or suspected allergies?  Yes  No If yes, specify \_\_\_\_\_

## Health History

Indicate if you *currently have or have ever had* any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fracture	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol/Drug Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies/Sinus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Head/Neck Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated/Bulging Disc	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Atherosclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	High/Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Clot	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Dislocation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sciatica	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scoliosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spinal Fracture	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bursitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spinal Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Back Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sprain/Strain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Carpal Tunnel Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Meningitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tendonitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Decreased Sensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tennis/Golfer's Elbow	<input type="checkbox"/> Yes <input type="checkbox"/> No
Degenerative Disc	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	TMJ	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness/Vertigo	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Earache	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck Pain/Stiffness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor/Growth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Uneven Leg Length	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss/Gain	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other \_\_\_\_\_

Describe/explain any treatment(s) you have had or are currently receiving for any of the conditions checked 'Yes' above. \_\_\_\_\_

List all past/present injuries, dislocations, broken bones and/or surgeries with date.

_____	Date _____
_____	Date _____
_____	Date _____
_____	Date _____
_____	Date _____

### Medications & Supplements

List all medications, vitamins, minerals and/or herbs you are currently taking and reason.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

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\_\_\_\_\_

## Health History

### Family Health History

Mother  Living  Deceased Reason for death \_\_\_\_\_  
Father  Living  Deceased Reason for death \_\_\_\_\_  
Maternal Grandmother  Living  Deceased Reason for death \_\_\_\_\_  
Maternal Grandfather  Living  Deceased Reason for death \_\_\_\_\_  
Paternal Grandmother  Living  Deceased Reason for death \_\_\_\_\_  
Paternal Grandfather  Living  Deceased Reason for death \_\_\_\_\_

### WOMEN ONLY:

Are you pregnant?  Yes  No  Trying  Maybe If yes, how many weeks? \_\_\_\_\_

Method of birth control? \_\_\_\_\_

Age of First Menses: \_\_\_\_\_ Date of Last Menses: \_\_\_\_\_ Age of Menopause: \_\_\_\_\_

Typical Length of Menses (days you bleed): \_\_\_\_\_ Typical Length of Cycle (from 1st day of one cycle to 1st day of next): \_\_\_\_\_

Number of: Pregnancies \_\_\_\_\_ Births \_\_\_\_\_ Abortions \_\_\_\_\_ Miscarriages \_\_\_\_\_

Hysterectomy?  Yes  No If yes, partial or complete? \_\_\_\_\_ Date \_\_\_\_\_

#### Check all that apply to you:

Scanty Flow  Abnormal Pap Smear  Breast Lumps  Irregular Cycles  Infertility  
 Heavy Flow  Menopausal Symptoms  Nipple Discharge  Low Libido  Fibroids  
 Clotting  Premenstrual Problems  Fibrocystic Breasts  Excessive Libido  Endometriosis  
 Vaginal Discharge  Painful Periods  Bleeding Between Cycles  Painful Intercourse  Ovarian Cysts  
 Other \_\_\_\_\_

### MEN ONLY:

#### Check all that apply to you:

Low Libido  Impotence  Seminal Emissions  Prostate Problems  Testicular Redness  
 Excessive Libido  Painful Intercourse  Premature Ejaculation  Testicular Pain  Testicular Swelling  
 Vasectomy Date \_\_\_\_\_  Other \_\_\_\_\_

## Lifestyle

Diet:  Normal  Vegetarian  Vegan  Lactose-free  Gluten-free  Other \_\_\_\_\_

Foods you crave: \_\_\_\_\_ When? \_\_\_\_\_

Daily Intake: Water \_\_\_\_\_ Soda \_\_\_\_\_ Caffeine?  Yes  No Coffee \_\_\_\_\_ Caffeine?  Yes  No Tea \_\_\_\_\_ Caffeine?  Yes  No

Do you drink alcohol?  Yes  No If yes, how much? \_\_\_\_\_ How often? \_\_\_\_\_ What kinds? \_\_\_\_\_

Do you smoke cigarettes?  Yes  No If yes, how many per day? \_\_\_\_\_

Do you use any other type of tobacco?  Yes  No If yes, what type and how often? \_\_\_\_\_

Have you smoked cigarettes or used other tobacco in the past?  Yes  No If yes, when did you stop? \_\_\_\_\_

Do you use recreational drugs?  Yes  No If yes, what type and how often? \_\_\_\_\_

Have you used recreational drugs in the past?  Yes  No If yes, when did you stop? \_\_\_\_\_

Do you have a high stress level?  Yes  No If yes, explain \_\_\_\_\_

Do you exercise?  Yes  No If yes, how often? \_\_\_\_\_ What kind? \_\_\_\_\_

## Personal Health Inventory

Please put a check mark (✓) by the symptoms that you have now.

Place a star (\*) next to the ones you have noticed within the last three months.

### Qi, Blood, Yin, Yang

- anxiety
- catch colds easily or frequently
- chest pain traveling to shoulder
- cold feet
- cold hands
- difficult to concentrate
- dizziness
- dream disturbed sleep
- dry skin
- fatigue
- feverish in the afternoon or flushes
- general weakness
- heat sensations in hands, feet, chest
- insomnia
- mental confusion
- night sweats
- palpitations
- restlessness
- sores on tip of tongue
- speech problems
- sweat easily
- thirst, at night
- feel worse after exercise
- see floating black spots

### LU

- allergies
- chills alternating with fever
- cough
- difficulty breathing
- dry mouth, throat, nose
- feeling achy
- headaches
- nasal discharge
- nose bleeds
- shortness of breath
- sinus congestion
- sneezing
- sore throat
- stiff neck/shoulders

### SP

- abdominal bloating and/or gas after eating
- belching
- chest congestion
- constipation
- diarrhea
- eating disorder
- fatigue after eating
- gas
- general feeling of heaviness in body
- hemorrhoids
- loose stools
- low appetite
- mental heaviness, sluggishness or fogginess
- nausea
- prolapsed organs (previously diagnosed)
- swollen feet
- swollen hands
- bruise easily

### ST

- bad breath
- belching
- bleeding, swollen or painful gums
- burning sensation after eating
- constipation
- heartburn
- large appetite
- mouth sores (canker or cold sores)
- stomach pain
- vomiting

### HT/PC

- chest pain
- edema
- high blood pressure
- insomnia
- low blood pressure
- palpitations
- stroke
- varicose veins

### LR/GB

- bitter taste in mouth
- blood shot eyes
- blurred vision
- chest pain
- convulsions
- diarrhea alternating with constipation
- difficulty swallowing
- dry eyes
- feeling of a lump in the throat
- headache at top of the head
- hot flashes
- muscle spasms, twitching, cramping
- numbness of hands and feet
- pain in rib cage
- red, sore or irritated eyes
- seizures
- skin rashes
- tight feeling in chest
- TMJ or locked jaw
- anger easily
- feel better after exercise

### KI/BL

- frequent urination
- hair loss
- joint pain
- lack of bladder control
- loose teeth
- low back pain
- memory problems
- night blindness or low vision
- ringing in your ears
- sore, cold or weak knees
- get up more than one time at night to urinate

### Other

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## 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: **Jean Brannon, L.Ac., Manju Ladha, L.Ac. and/or Hui Wang, L.Ac.**

(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, 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 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, 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 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

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## Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Village Health Wellness Spa 'Notice of Privacy Practices'. This notice describes how Village Health Wellness Spa may use and disclose by protected health information, certain restrictions on the use and disclosure of my healthcare information, and the rights that I have regarding my protected health information.

Sign  
Here  
→

\_\_\_\_\_  
**Signature** of Patient, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

## Pediatric Consent (If patient under the age of 18)

N/A (I am age 18 or older)

I, being the parent or legal guardian of \_\_\_\_\_ (**patient name**), hereby consent to the treatment of my child by Village Health Wellness Spa. I understand that the nature of the treatment may include examination, acupuncture treatment, recommendation of herbal formula(s), and/or various ancillary procedures such as cupping, herbal rub, ear seeds and moxibustion.

\_\_\_\_\_  
**Signature** of Patient, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date