acupuncture profile & release form

village health
wellness spa

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) _____

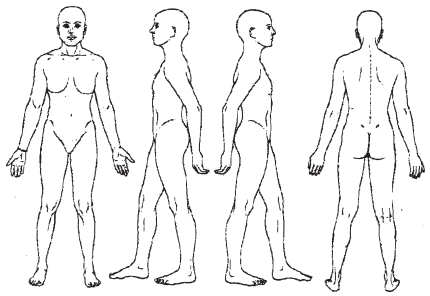
Type of pain: ☐ Sharp ☐ Burning ☐ Throbbing ☐ Numbness ☐ Aching ☐ Swelling ☐ Dull
☐ Tingling ☐ Stabbing ☐ Shooting ☐ Stiffness ☐ Other _____

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 _____

Mark an X on any area(s) where you have pain, numbness and/or tingling.



front left side right side back

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 _____

Are you taking any type of blood thinner? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

Have you ever had an Acupuncture treatment? ☐ Yes ☐ No

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

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 _____

_____

_____

_____

_____

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.

(Date)

PATIENT SIGNATURE **X**

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

(Date)

OFFICE SIGNATURE **X**

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ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

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