Acupuncture One Wellness Center

31348 Via Colinas Suite 105 Westlake Village, CA 91362 Phone: (818) 575-9096 Fax: (818) 575-9098

Patient Personal Information

These forms are **CONFIDENTIAL** and are vital to help us determine the best possible treatment for you. Please fill out **all** the forms to the best of your knowledge.

Today's Date: _____/_____/_____
Month Day Year

Name: _____ _____ _____
(Last) (First) (M.I.)

Home Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone #'s: Home _____-_____-_____ Cell: _____-_____-_____

E Mail Address: _____

Date of Birth: ____/____/_____ Age: ___ Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Other

S.S.N: _____ Driver's License # _____

Emergency Contact # _____/_____/_____ Relationship: _____

Employed: Yes: ___ No: ___ Retired: Yes: ___

Employer's Name: _____ Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Employer's Phone #: _____-_____-_____

Health Insurance: Yes: ___ No: ___ Insurance Company's Name: _____

Insured Name: _____ ID# _____

Insured Date of Birth: _____/_____/_____
Month Day Year

Relationship to Insured: Self: _____ Spouse: _____ Child: _____ Other: _____

18 years and under, person's name responsible for your treatment: _____

Have you had acupuncture treatment before? Yes: ____ No: ____

Whom may we thank for the referral? _____

Or How were you referred to us? _____

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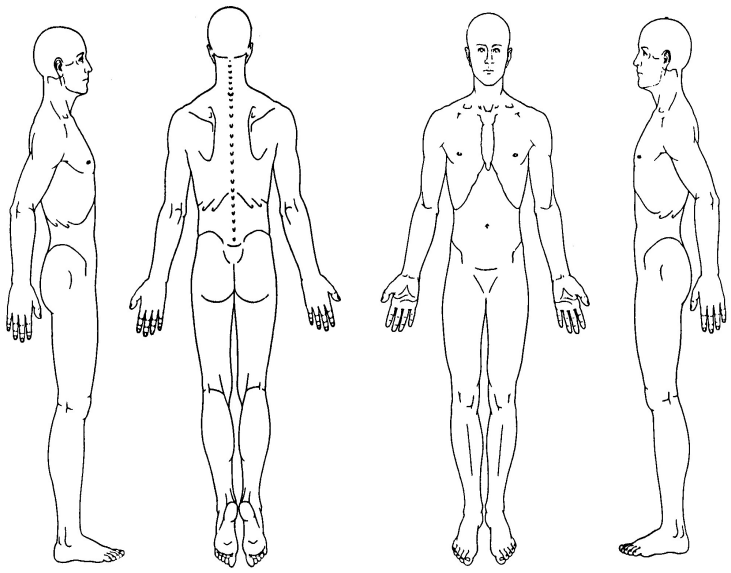
Name: _____ Date: _____ / _____ / _____

Height: _____ Weight: _____ Blood pressure: _____/_____

Chief Complaints (What are the chief complaints you would like us to help you with?)



Mark Pain Areas

How long have you had this particular problem? (Be specific)?

What other forms of treatment have you sought?

Are you taking any medications? If yes, Please list all:

_____

- Pain began: ☐ Gradually ☐ Suddenly ☐ Don't know
- Is your pain worse when you: ☐ Sit ☐ Bend ☐ Walk ☐ Run ☐ Exercise ☐ Lift ☐ Push ☐ Pull ☐ Rest ☐ Other: _____
- Is the pain: ☐ Burning ☐ Stabbing ☐ Sharp ☐ Dull/Achy ☐ Numb ☐ Constant
- Which of the following areas do you have pain, discomfort, or restriction of motion: ☐ Neck ☐ Shoulder☐ Arm ☐ Hands ☐ Wrist ☐ Upper Back ☐ Mid Back ☐ Low Back ☐ Pelvis ☐ Hip ☐ Legs ☐ Knees ☐ Feet ☐ Ankles Other: _____
- Does your Pain travel: ☐ Yes ☐ No If yes, describe: _____
- When is the pain worst: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night
- Does your pain interfere with your: ☐ Work ☐ Sleep ☐ Daily routine
- How would you rate your pain on a scale 1 to 10, with 10 being the most extreme: 1 2 3 4 5 6 7 8 9 10

HEALTH CONDITIONS

・Surgeries: _____

・Traumas: (Auto accident / fall / other:) _____

・Allergies: (Drugs / Chemicals / Food/ Other:)_____

Please check all that apply to you.

☐ Allergies	☐ Anxiety	☐ AIDS/HIV	☐ Arthritis
☐ Asthma	☐ Back pain	☐ Blurred vision	☐ Breathing difficulties
☐ Cancer	☐ Carpal tunnel syndrome	☐ Chest pain	☐ Chronic fatigue
☐ Constipation	☐ Depression	☐ Diabetes	☐ Diarrhea
☐ Difficult concentration	☐ Digestion problems	☐ Dizziness	☐ Fibromyalgia
☐ Frequent urination	☐ Feeling cold	☐ Feeling hot	☐ Foot pain
☐ Gastrointestinal disorder	☐ Gout	☐ Glaucoma	☐ Hepatitis
☐ High blood pressure	☐ Headache	☐ Heart problems	☐ Hives
☐ Insomnia	☐ Irritable bowel syndrome	☐ Immune deficiency	☐ Itchiness
☐ Lupus	☐ Lyme's disease	☐ Menstrual disorder	☐ Neck pain
☐ Numbness & tingling	☐Palpitation (heart)	☐ Poor appetite	☐ Persistent cough
☐ Sciatica	☐ Shoulder pain	☐ Spinal misalignment	☐ Spinal fusion
☐ Skin problem	☐ Stress	☐ Tendonitis	☐ T.M.J
Other (please specify)			

Briefly describe Family History:

・Mother's side: _____

・Father's side: _____

Women Only:

・Age of first period: ____・Date of last period: _____・Menstruation: ☐ Normal ☐ Irregular ☐ Painful
・Amount: ☐ Normal ☐ Excessive ☐ Little
・Color: ☐ Normal ☐ Dark ☐ Bright ☐ Clots
・Cramping: ☐ Yes ☐ No ☐ Mild ☐ Moderate ☐ Severe
・Discharge: ☐ Yes ☐ No ・ Between periods: ☐ Yes☐ No
・Color: ☐ Normal ☐ Dark ☐ Bright ☐ Clots ・PMS: ☐ Yes ☐ No
・History of Pregnancy:
Pregnancies Number: ___ Births: ___ Miscarriages: ___ C-Section: ___ Premature births: ___ Abortions: ___
・Hysterectomy: Year: _____ Hot Flashes: __ If yes, how many? ___ Night Sweats: __ If yes, how many?___

Nutrition and Lifestyle:

・How is your appetite? _____ Do you have regular eating habits? ☐ Yes ☐ No If no, _____times a day
・Do you crave certain foods? ☐ Yes: ___ ☐ No: ___ If yes, what foods do you crave? _____
・Do you smoke? ☐ Yes ☐ No ・Do you drink? ☐ Yes ☐ No ・How often _____, how many glasses _____
・Do you exercise regularly? ☐ Yes ☐ No If yes, What exercises do you do regularly? _____
・Do you sleep well? Yes ☐ No ☐ Do you get enough sleep at night? ☐ Yes ☐ No
・How many hours do you sleep at night? _____
・How often do you wake up during the night? _____ ・The reason for waking _____
・Describe the quality of sleep you get _____
・Are you under a lot of stress? ☐ Yes ☐ No ・Work related? ☐ Yes ☐ No
・How do you manage your stress? _____
・Do you get angry easily? ☐ Yes ☐ No Do you cry easily? ☐ Yes ☐ No
・Do you ever feel a lump in your throat? ☐ Yes ☐ No ・Do you have lots of phlegm? ☐ Yes ☐ No
・How is your digestion? ☐ Good ☐ Bad ☐ Heartburn☐ Acid reflux ☐ Cramping ☐ Bloating ☐ Stomach gas
・How is your urination? ☐ Normal ☐ Frequent ☐ Burning sensation ・Color: ☐ Clear ☐ Yellow

・How are your bowel movements? ☐ Normal ☐ Constipated ☐ Diarrhea ・Stool: ☐ Firm ☐ Loose
☐ Abdominal gas ☐ Abdominal cramping
・Do you feel thirsty? ☐ Yes ☐ No Dry mouth: ☐ Yes ☐ No Bitter taste: ☐ Yes ☐ No
・Do you drink lots of water? ☐ Yes ☐ No If yes, why? ☐ Thirsty ☐ Habit ☐ For health
・Do you have feelings of nausea? ☐ Yes ☐ No Do you vomit often? ☐ Yes ☐ No
・Do you have headaches? ☐ Yes ☐ No If yes, where? ☐ Forehead ☐ Sides ☐ Back ☐ Top ☐ Whole
・How is your energy level? ☐ High ☐ Medium ☐ Low

Do not write below this line:

(OFFICE USE ONLY)

Pulse:	Tongue:
Diagnosis:	
Treatment Principle:	
Acupuncture Points:	
Recommendation / Comments:	
Notes:	

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OFFICE POLICIES

Welcome to the Acupuncture One Center. We want you to be comfortable and to receive the best care possible. Please do not hesitate to ask any questions you might have regarding your visit, your billing, or our policies.

FEES: The fees charged in this office are comparable to those charged by other healthcare providers in this area, with similar qualifications. Please ask to see our fee schedule. We accept cash, credit card, and personal checks. Please note there is a $25.00 charge for checks returned due to insufficient funds.

INSURANCE COVERAGE: Many insurance policies cover Acupuncture, but we do not claim that yours does. Policies can differ greatly in terms of deductible and percentage of coverage for Acupuncture. We can verify coverage and submit your claim form for reimbursement, provided you sign financial agreement below.

RELEASE OF INFORMATION: Your insurance company may require medical reports to document our treatment and progress. Your initials below authorize the release of medical information necessary to process your claim.

CANCELLATION POLICY: As a courtesy to our office and other patients, we ask that you please notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment. You will be charged a $25.00 fee for cancellation giving less than 24 hours notice for any non-emergency situations. Should you cancel an appointment without 24 hours notice, or no-show for a scheduled appointment, an equivalent amount of one full session will be charged.

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS

I, _____, am receiving or about to receive health care services in this office. I understand that I am responsible to pay all non-insurance related fees when services are rendered, including herbs, etc. If I choose to use my insurance I understand I will be responsible for all "non-covered" services and/or coinsurance/co- pays associated with my office visit.
In addition I authorize insurance payment of medical benefits to Acupuncture One Wellness Center.

By signing below, I agree to comply with the office policies stated above which I have read and understood. I also authorize the use of this signature on all insurance submissions.

Signed _____ Date _____

- **Consent Form for Treatment by Cupping Therapy (If necessary)**

I give my full permission for Dr. Lee to perform dry, wet, or fire cupping therapy. I fully understand why he has decided on this method of treatment for me. I have been made aware that cupping may leave marks, bruising, or in rare cases, small blisters.
I may also experience soreness for a few days in the area cupped.

I will not hold the Dr. or any of the clinic staff responsible should any of the above happen. By signing below, I show I have read the above Consent Form for Treatment by Cupping Therapy and have had the opportunity to ask questions.

Patient Signature: _____

Date: ____/____/_____

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 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 (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 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 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.

I do not expect the clinical staff to be able to anticipate and explain all the 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.

(Date)

PATIENT SIGNATURE **X**

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

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by 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, 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 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.

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 the California medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). 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 limitation, 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 a 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 a 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.

(Date)

PATIENT SIGNATURE **X**

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

(Date)

OFFICE SIGNATURE **X**