THRIVE | ACUPUNTURE

NEW PATIENT INTAKE FORM

NAME				TODAY'S DATE	
ADDRESS				DATE OF BIRTH	GENDER: M F
				MARITAL STATUS	
HOME PHONE				CELL PHONE	
E-MAIL				EMERGENCY CONTACT	NAME: PHONE #:
REFERRED BY:				Reason for Visit Today:	
Have you had Acupuncture before?	Y N	Used Chinese Herbal Medicine before?	Y N		
How long have you had this condition?		Is it getting worse?		What conditions make it either better or worse (please list): BETTER:	
Are you under a physician's care?	Y N	If yes, for what		WORSE:	
Physicians Name and Phone Number:				Please list other concurrent therapies:	

FAMILY MEDICAL HISTORY

- ❑ Allergies (list)

_____
_____
_____
_____

- ❑ Arteriosclerosis
- ❑ Asthma
- ❑ Alcoholism
- ❑ Cancer: _____
- ❑ Depression
- ❑ Diabetes – Type _____)
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Seizures
- ❑ Stroke

YOUR PAST MEDICAL HISTORY (Please check any of the following conditions you have or if in the past if they were a significant part of your medical history)

- ❑ AIDs/HIV
- ❑ Alcoholism
- ❑ Allergies
- ❑ Appendicitis
- ❑ Arteriosclerosis
- ❑ Asthma
- ❑ Birth Trauma (your own)
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Diabetes – Type _____)
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Goiter
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis – Type _____)
- ❑ Herpes – Type _____)
- ❑ High Blood Pressure
- ❑ Measles
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pacemaker – Date:
- ❑ Pleurisy
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Seizures
- ❑ Stroke
- ❑ Surgery (list)

_____
_____

- ❑ Thyroid Disorder
- ❑ Major Trauma (list)

_____
_____
_____

- ❑ Tuberculosis
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Whooping Cough
- ❑ Other (Specify

_____
_____
_____
_____
_____

YOUR DIET (Please check all that apply)

- ❑ Low Appetite
- ❑ High Appetite
- ❑ Coffee / Tea
- ❑ Soft Drinks / Fruit Juices
- ❑ Low Protein Intake
- ❑ High Protein Intake
- ❑ Artificial Sweeteners
- ❑ Sugar
- ❑ Salty Foods
- ❑ Glasses of Water per Day: _____

Vitamins/Supplements (past 2 months):_____
_____
_____

Pharmaceuticals (past 2months):_____
_____

YOUR LIFESTYLE (Please check all that apply)

- ❑ Alcohol
- ❑ Tobacco
- ❑ Marijuana
- ❑ Other Drugs
- ❑ High Stress
- ❑ Occupational Hazards
- ❑ Regular Exercise

Type: _____ Frequency: _____
Type: _____ Frequency: _____

GENERAL SYMPTOMS (Please check all that apply)

- ❑ Poor Appetite
- ❑ Heavy Appetite
- ❑ Strongly like cold drinks
- ❑ Strongly like hot drinks
- ❑ Recent weight loss/gain
- ❑ Poor sleep
- ❑ Heavy sleep
- ❑ Dream disturbed sleep
- ❑ Fatigue
- ❑ Lack of Strength
- ❑ Bodily heaviness
- ❑ Cold hands / feet
- ❑ Poor circulation
- ❑ Shortness of breath
- ❑ Fever
- ❑ Chills
- ❑ Night sweats
- ❑ Perspire easily
- ❑ Muscle cramps
- ❑ Vertigo / Dizziness
- ❑ Bleed or bruise easily
- ❑ Peculiar taste in mouth (describe)

_____
_____

- ❑ Other Symptoms:

_____

HEAD, EYES, NOSE, THROAT (Please check all that apply)

- ❑ Glasses (Age: _____)
- ❑ Eye strain
- ❑ Eye pain
- ❑ Red eye
- ❑ Itchy eyes
- ❑ Spots in eyes
- ❑ Poor vision
- ❑ Blurred vision
- ❑ Night blindness
- ❑ Myopia or Presbyopia
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Teeth problems
- ❑ Shortness of breath
- ❑ Grinding teeth
- ❑ TMJ
- ❑ Facial pain
- ❑ Gum problems
- ❑ Sores on lips or tongue
- ❑ Dry mouth
- ❑ Excessive saliva
- ❑ Sinus problems
- ❑ Excessive phlegm
  Color: _____
- ❑ Recurrent sore throat
- ❑ Swollen glands
- ❑ Lumps in throat
- ❑ Enlarged thyroid
- ❑ Nosebleeds
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Earaches
- ❑ Headaches
- ❑ Migraines
- ❑ Concussions
- ❑ Other head or neck problems

_____
_____
_____

RESPIRATORY (Please check all that apply)

- ❑ Difficulty breathing when lying down
- ❑ Shortness of breath
- ❑ Tight chest
- ❑ Asthma / Wheezing
- ❑ Difficulty inhaling / exhaling
- ❑ Dry cough
- ❑ Wet cough
- ❑ Thick phlegm
- ❑ Thin phlegm
- ❑ Cloudy or dark phlegm
- ❑ Coughing up blood
- ❑ Pneumonia
- ❑ Other respiratory problems

_____
_____
_____
_____

CARDIOVASCULAR (Please check all that apply)

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Blood clots
- ❑ Fainting
- ❑ Chest pain
- ❑ Difficulty breathing
- ❑ Tachycardia
- ❑ Heart palpitations
- ❑ Phlebitis
- ❑ Irregular heartbeat
- ❑ Pacemaker
- ❑ Other cardiovascular problems

_____
_____
_____

GASTROINTESTINAL (Please check all that apply)

- ❑ Nausea / Vomiting
- ❑ Acid regurgitation
- ❑ Gas
- ❑ Hiccups
- ❑ Bloating
- ❑ Bad breath
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stools
- ❑ Bloody stools
- ❑ Mucus in stools
- ❑ Hemorrhoids
- ❑ Itchy anus
- ❑ Intestinal pain / cramping
- ❑ Burning anus
- ❑ Rectal pain
- ❑ Anal fissures
- ❑ Laxative use

What kind: _____
_____
Frequency: _____

Bowel Movements
Frequency: _____
Color: _____
Firm / Loose: _____
Odor: _____

MUSCULOSKELATAL (Please check all that apply)

- ❑ Neck / Shoulder pain
- ❑ Muscle pain
- ❑ Upper back pain
- ❑ Lower back pain
- ❑ Joint pain
- ❑ Rib pain
- ❑ Limited range of motion
- ❑ Limited use

Other problems: (please describe)
_____
_____

SKIN & HAIR (Please check all that apply)

- ❑ Rashes
- ❑ Hives
- ❑ Ulcerations
- ❑ Eczema
- ❑ Psoriasis
- ❑ Acne
- ❑ Dandruff
- ❑ Itchy scalp
- ❑ Hair loss
- ❑ Change in hair / skin texture
- ❑ Fungal infections

Other hair or skin problems: (describe)
_____
_____

NEUROPSYCHOLOGICAL (Please check all that apply)

- ❑ Seizures
- ❑ Numbness
- ❑ Tics
- ❑ Poor memory
- ❑ Depression
- ❑ Anxiety
- ❑ Irritability
- ❑ Easily stressed
- ❑ Abuse survivor
- ❑ Considered/Attempted suicide
- ❑ Seeing a therapist

Other: (please specify)
_____
_____

GENITOURINARY (Please check all that apply)

- ❑ Pain when urinating
- ❑ Frequent urination
- ❑ Urgent urination
- ❑ Blood in urine
- ❑ Unable to hold urine
- ❑ Incomplete urination
- ❑ Venereal disease
- ❑ Bedwetting
- ❑ Wake to urinate
- ❑ Increased libido
- ❑ Decreased libido
- ❑ Kidney stone
- ❑ Premature ejaculation
- ❑ Nocturnal emission

GYNECOLOGY (Please check all that apply)

- ❑ Age menses began: _____
- ❑ Length of cycle: _____
- ❑ Duration of flow: _____
- ❑ Irregular periods
- ❑ Painful periods
- ❑ PMS
- ❑ Vaginal discharge
  Color: _____
- ❑ Vaginal sores
- ❑ Vaginal odor
- ❑ Clots
- ❑ Breast lumps

Pregnancies: _____
Live births: _____
Premature births: _____
Age at menopause: _____
Date of last PAP: _____
Date last period began: _____

OTHER:

_____
_____
_____

THRIVE | ACUPUNCTURE

WELCOME TO THRIVE!

We are so glad you chose to include us on your journey to wellness and well-being. ***Here are a few guidelines for our office:***

PROMPTNESS: Please arrive 10 minutes prior to your scheduled appointment. Late arrivals will receive the time remaining in that scheduled hour for treatment.

CANCELLATION POLICY: A 24-hour cancellation notice is required. Listed below is our schedule of fees for cancellations:

24+ hour notice cancellation	No charge
Less than 24 hour notice	$20.00
Less than 2 hour notice	Full Appointment Fee
Missed appointments	Full Appointment Fee

CELL PHONES: To ensure a peaceful experience for all in the office, please silence your phones while in the building.

PAYMENT: Patients are responsible for payment at the time of treatment (this includes any cost not covered by insurance).

RETURNED CHECKS: Patients will be charged $25.00 for any returned checks.

We at **THRIVE** are committed to providing you with expert medical care, in a safe, comfortable, and relaxing environment. Please let us know of any suggestions you have to make your experience more enjoyable.

I have read, and understand the above policies:

PATIENT SIGNATURE _____ **DATE** _____

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 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, 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 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)
OFFICE SIGNATURE	X	(Date)

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

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 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. 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.

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.

(Date)

PATIENT SIGNATURE X

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE