Initial Consult & Treatment
Confidential Intake Form

DATE OF INITIAL VISIT:____________________ DOB:____________________ AGE:___________

NAME:____

ADDRESS:____

STATE:____________ ZIP:________ MOBLE NUMBER: _________________________________

EMAIL:____

OCCUPATION:_______________________________________

MARITAL/RELATIONSHIP STATUS:____________________ REFERRED BY:___________________

Client Confidentiality and Release Form
I understand this modality is not a replacement for medical care. The practitioner does not diagnose medical illness, disease or other physical or mental conditions unless specified under his/her professional scope of practice. As such, the practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform spinal manipulations (unless specified under his/her professional scope of practice). The practitioner may recommend referral to a qualified health care professional for any physical or emotional conditions I may have. I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.

Confidentiality of medical and personal information obtained during the course of the practitioner's work is of the utmost importance. HIPAA regulations require all practitioners obtain a signed release form from their client *before* taking any information about them. The best way to be fully compliant is to obtain this release signature at the initial consultation. Clients should receive a copy of the form they signed (upon request), and the practitioner maintains a copy for their records

I, (name)____
give my permission, for my practitioner to take notes including health history/ medical and /or personal information I choose to disclose to him/her.

Client Signature: ____ Date: ___________________

Practitioner
signature____Date:_____________________

REASON FOR VISIT/CHIEF COMPLAINT:

Primary reason for visit:____

When did your first notice it?____

What brought it on?____

Describe any stressors occurring at the time:

____

What activities provide relief?_______________________________________

What makes it worse?____

Is this condition getting worse?__________ interfere with work ______ sleep______ recreation_______

What kind of Treatments have you had? Results?

____

____

SECONDARY COMPLAINT:

Significant Illnesses:	Allergies:
☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Thyroid Disease ☐ Hepatitis ☐ Cancer ☐ Seizures ☐ HIV ☐ Other	Major Operations: Accidents/significant Traumas: Medicines (taken within the last 6 months including drugs, vitamins and herbs:

Please review and check the following:

	Past	Present		Past	Present
Asthma			**Sore heels when walking**		
Cold Hands or feet			**Anxiety**		
Swollen ankles			**Depression**		
Sinus Conditions Frequent Colds			**Sleep Disturbance**		
Seizures			**Fainting Spells**		
Low Back Pain			**Muscular Tension: Location:**		
Skin Disorders: Type			**Varicose Veins Hemorrhoids Location**		
Sciatica			**Herniated/Bulging Discs**		
Painful/Swollen Joints			**Artifical/Missing limbs**		
High or Low Blood Pressure			**Contact Lenses**		
Dentures/ Partials			**Cancer (past or current) Type**		
Headaches Type:			**Numbness in feet or legs when standing**		

NOTES:

FAMILY HISTORY:

	Still Living?	**Cause and Age of Death**	**Major Health Issues**
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Paternal Grandmother			

GASTROINTESTINAL HELATH HISTORY:

Describe your typical Breakfast:____

Lunch:____

Dinner:____

Snacks:____

Water Intake(glasses/day) _________________________ Caffeine_________________

What is the worst item in your diet____

What foods are your weakness____

Are you subject to binge eating?_____________ What foods_____________________________

Do you experience bloating/gas/burps after eating?_____________What foods trigger this?____________________

Food Allergies?_________Describe____

How often are your bowel movements?___________________________Do your stools: sink______ float _______

Constipation?__________Blood in stool ?_________Mucus in stool?____________Pain when stooling?_________

Diarrhea?__________ Other: ____

LIFESTYLE, EMOTIONAL & SPIRITUAL:

What is your opinion of yourself?____

Describe the most positive emotion you experience____

When and Where do you experience this emotion? ____

Describe the most negative emotion you experience____

When and Where do you experience this emotion?____

Describe your Spiritual and/or Religious practice:____

On a scale of 1 – 10 *(1 being the lesser, 10 the greater*) Please rate yourself in each of these qualities:

Faith____ Hope____ Charity____ Generosity____ Sense of Humor____ Fear_____ Grief_____ Sense of Fun_____

What hobbies/ activities provide you with pleasure and accomplishment:

____

Describe your exercise routine (type, frequency)____

What changes would you like to achieve in 6 months: ____

One Year**:** ____

Do you use Tobacco?__________ Quantity:_______/ppd Alcohol?________ Quantity: ________ ounces/ day

Marijuana?______ Quantity:______ Other:____

Have you been under treatment for substance use?____

NOTES:

Female Reproductive Health History:

Method of Contraception (circle):

pills ~ patch ~ diaphragm ~ injection ~ condoms ~ IUD ~ abstinence ~ rhythm method ~ Fertility Awareness ~ Other:____

Length of time using method__________Last Pap smear______________Results _______________

Are now or in the past experiencing Fertility Challenges? Yes___No___ Describe your treatment IVF,etc):

Menstrual History Review and check as indicated:

Age of Menses:___________________What was this like for you?__________________________

Last Menstrual Period:_____________________Length of Menses_________________________

Are you trying to Conceive? Yes_____No_______ Are you Pregnant? Yes____No____Unsure____

	Past Present		
Heaviness in Pelvis prior to menses		Dark Thick Blood at: Beginning/End /Both	
Excessive Bleeding Pads per Hour		Headache or Migraine with menses	
Dizziness		Bloating	
Water Retention		Ovulation: Painful/ Failure to	
Endometriosis Location (if known)		Fibroids Location (if known)	
Uterine or Cervical Polyps		Uterine Infection(s)	
Vaginal Infection(s)		Cysts/Location:	
Bladder Infection(s)		Urinary Incontinence	
Painful Intercourse		Vaginal Dryness	
Episodes of Amenorrhea How long?		Irregular cycles: Early/Late	
Painful Periods			

Rate your interest in Sex: High _________ Moderate__________ Low______________ None________

Do you have or ever had difficulty experiencing orgasms___________

Have you experienced trauma? Yes___No____ Describe_______________________________________

Did you undergo counseling for this: ____

What was this like for you____

PREGNANCY HISTORY:

Number of Pregnancies: ____ Dates ____

Miscarriage(s) ______ Dates ____________________ Termination(s) ______ Dates:____________________

Number of Births:_________ Dates:____

Complications for any of the above, describe:____

Premature Births?______ Spotting During Pregnancy? _____Weak Newborns? ______Incompetent Cervix? ______

Describe your experience with:

Pregnancy:____

Labor:____

Birthing____

Post
Partum:____

Maternal Family History of (*please circle*) Infertility Fibroids Endometriosis PMS Menopause

Cancer(type) ______________ Menstrual Problems _______________ Other_________________________

Medications your mother took when she was pregnant with you (if any) ____________________________

Your Birth Trauma (if known) ____

MENOPAUSE:

Age symptoms began:__________ Are they getting worse___________ better___________ same_________

Are you on/ or ever been on hormone replacement therapy?_______ if so, how long____________________

Name and dose ____

Reason for stopping ____

Age of Mother at menopause:_______ Concerns/Experience ________________________________

Check the following symptoms that apply to you:

Hot flashes	Insomnia	Fatigue	Memory Loss	Mood Swings
Vaginal Discharge	Dry Vagina	Depression	Anxiety	Irritability
Spotting	Flooding	Irregular Menses	Painful Intercourse	Increased Libido
Decreased Libido	Disturbed Sleep Pattern			

Additional Information you feel important your practitioner should know that is not mentioned here:

INFORMED CONSENT & PROCEDURE

With Dr. Bella Lauren DOM, AP and Dr. Keith Cini DOM, AP

I hereby request and consent to the performance of Oriental medicine, acupuncture treatments and other procedures within the scope of the practice of /Oriental Medicine/Acupuncture/Midwifery/Massage on me (or on the patient named below, for whom I am legally responsible) by the Acupuncturist or Midwife named above and/or other licensed acupuncturists &/OR Midwives who now or in the future treat me while employed by, working or associated with or serving as back-up for the Acupuncturist & Midwife named above, including those working at the clinic or office listed above 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, midwifery, 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 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 treatment for my present condition and for any future condition(s) for which I seek treatment.

Date: ___________________________

Patient Name: __________________________________ Patient Signature: ____________________________

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

FINANCIAL POLICY

Providing quality care for our patients is our primary concern. It is, however, the responsibility of the patient to know and understand the guidelines of their insurance policy. As many insurance policies do not cover Acupuncture please discuss any questions or concerns with your insurance company. Payment is expected at the time services are rendered. We do offer package rates for certain treatments. Please note that these packages cannot be transferred to another patient or converted as payment towards a different treatment unless arranged with the physician at the time of purchase. For your convenience, we accept cash, checks, and most major credit cards.

MISSED APPOINTMENT

If you need to cancel your appointment please do so 24-48 hours in advanced from your appointment time. If we are not in the office please leave a voicemail. Please keep in mind that our office works on a scheduled appointment basis only. If you are unable to keep your scheduled appointment, please call and cancel the appointment. All appointments are expected to begin on time so your late arrival takes away from your treatment. If you expect you will be unable to make your appointment time, please call to reschedule. Early Cancelations have no fee. Late cancelations will result in a $75 late cancelation fee and no-shows will result in full fee of treatment missed.

Your signature below signifies your understanding and willingness to comply with our payment and missed appointment policies.

Date: ___________________________

Patient Name: _________________________________ Patient Signature: ____________________________

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

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 the 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 claims arising out of or relating to treatment of 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, 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 and 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 up 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 the 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 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. By my signature below, I understand that I have the right to receive a copy of this Arbitration Agreement.

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 Name: ________________________________ Patient Signature: ___________________________

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