LA Alternative Medical Center

Patient Information

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held confidential. Thank you.

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

Sex: [ ] Male [ ] Female

Marital Status: [ ] Single [ ] Married [ ] Other

Date of Birth: ____/____/_____
MM/ DD/ YYYY

Address: _____

City: _____ State: _____ Zip: _____

Tel: Home:_____ Cell:_____

Work:_____ E-mail:_____

Soc. Sec#:_____-____-_____ Driver's License#: _____

Occupation/Career:

_____

For emergency, who should we contact?

Name: _____ Tel: _____

How did you hear about us?

[ ] Website [ ] Weekly magazine [ ] Newspaper

[ ] Referred by: _____

[ ] Other: _____

Signature: _____ Date Signed: _____

Health Care Provider-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 California law, and not by a lawsuit or resort to court process except as California 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 the intention of the parties that this agreement bind all parties whose claims may arise out of or relate 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 and the health care provider and/or other 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 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 estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the health care provider to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the health care provider, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

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 part 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 the provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this Arbitration Agreement including, but not limited to, section 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 Provisions**: Al claims based upon the same incident, transaction or related circumstances shall be arbitrated in one processing. 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 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.

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 below. Effective as of the date of first professional services.

_____
Patient's Initials

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.

_____ _____
Health Care Provider's Signature (Date) Print Patient's Name

By:_____ _____
Health Care Provider's Duly Authorized Representative (Date) Signature of Patient's Agent, Representative, or Parent (Date)

_____ As:_____
Translated by (Date) Relationship to Patient

A signed original copy is to field in Patient's file.

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.

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:

PATIENT SIGNATURE: **X** (Date)

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

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature:	_____	Parent / Guardian Signature	_____	Witness Signature	_____
Name	_____	Name	_____	Name:	_____
Date	_____	Date	_____	Date:	_____

INITIAL PATIENT VISIT FORM

Patient Name: _____ Date: ____/____/_____

Please provide the following medical information to the best of your ability.

What problems are you here for today?	**List any allergies to medications:**

Past Medical History:

1. Please check the "Yes" or No" box to indicate if you have any of the following illnesses; for "Yes" answers, please explain

	Yes	No			Yes	No	
Diabetes	☐	☐	_____	Stomach or intestinal problems	☐	☐	_____
Hypertension (high blood pressure)	☐	☐	_____	Allergy problems/therapy	☐	☐	_____
Thyroid problems	☐	☐	_____	Kidney problems	☐	☐	_____
Heart disease/cholesterol problems	☐	☐	_____	Neurological problems	☐	☐	_____
Respiratory problems	☐	☐	_____	Reproductive problems	☐	☐	_____
Bleeding disorder	☐	☐	_____	Other medical diagnosis	☐	☐	_____

2. Please list any operations (and dates) you have ever had (including tonsils and adenoids):

3. Please list any current medications:

4. Pleases check any of the treatment you have had for your current problem(s):

☐ Physical Therapy ☐ Chiropractic ☐ Nerve Block ☐ Massage ☐ Traction ☐ Others: _____

Social History:	Yes	No	**Please list details below**
Do you smoke? List how much?	☐	☐	
If no, did you smoke previously?	☐	☐	
Do you drink alcohol? List how often?	☐	☐	

Family History:

1. Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses.
   If yes, please indicate which relative(s) have the problems.

	Yes	No	
Heart problems/murmurs	☐	☐	
Allergy	☐	☐	
Diabetes	☐	☐	
Cancer	☐	☐	
Bleeding disorder	☐	☐	
Anesthesia problems	☐	☐	

Review of Systems:

1. **Please check the "Yes" or "No" box to indicate if you have any of the following symptoms.**
2. **For any "Yes" response, please check the "current" box if this symptom relates to the reason for your visit today.**

		Yes	No	Current		Yes	No	Current
GENERAL	Chills	☐	☐	☐	Fever	☐	☐	☐
	Fatigue	☐	☐	☐	Weight gain/ loss	☐	☐	☐
	Insomnia	☐	☐	☐	Daytime sleepiness	☐	☐	☐
ALLERGY	Environmental allergy	☐	☐	☐	Sneezing fits	☐	☐	☐

INITIAL PATIENT VISIT FORM

Patient Name: _____ Date: ____/____/_____

		Yes	No	Current		Yes	No	Current
EYES	Eye pain/pressure	☐	☐	☐	Vision changes	☐	☐	☐
ENT	Hearing loss	☐	☐	☐	Ear noises	☐	☐	☐
	Dizziness	☐	☐	☐	Lightheadedness	☐	☐	☐
	Nasal congestion	☐	☐	☐	Sinus pressure or pain	☐	☐	☐
	Hoarseness	☐	☐	☐	Problem snoring, apnea	☐	☐	☐
	Throat clearing	☐	☐	☐	Throat pain	☐	☐	☐
RESPIRATORY	Cough	☐	☐	☐	Coughing blood	☐	☐	☐
	Wheezing	☐	☐	☐	Shortness of breath	☐	☐	☐
CARDIAC	Chest pain	☐	☐	☐	Palpitations	☐	☐	☐
	Wake short of breath	☐	☐	☐	Ankle swelling	☐	☐	☐
GASTROINTESTINAL	Difficulty swallowing	☐	☐	☐	Heartburn	☐	☐	☐
	Stomachache	☐	☐	☐	Adnominal pain	☐	☐	☐
	Poor appetite	☐	☐	☐	Thirsty/drink lots of water	☐	☐	☐
	Constipation	☐	☐	☐	Diarrhea	☐	☐	☐
	Nausea/vomiting	☐	☐	☐	Rectal bleeding	☐	☐	☐
URINARY	Frequent urination	☐	☐	☐	Painful urination	☐	☐	☐
	Blood in urine	☐	☐	☐	Prostate problems	☐	☐	☐
HEMATOLOGY/	Swollen glands	☐	☐	☐	Night/Daytime Sweating	☐	☐	☐
LYMPHATIC	Bleeding problems	☐	☐	☐	Easy bruising	☐	☐	☐
ENDOCRINOLOGY	Feel warmer than others	☐	☐	☐	Feel cooler than others	☐	☐	☐
SKIN	Rash	☐	☐	☐	Hives	☐	☐	☐
	Itching	☐	☐	☐	Skin or hair changes	☐	☐	☐
GYNECOLOGY	Menstrual Pain	☐	☐	☐	Early/Late/No Period	☐	☐	☐
(FEMALE ONLY)	Pregnant	☐	☐	☐	No Period	☐	☐	☐
	Menopausal	☐	☐	☐	Prolonged Period	☐	☐	☐
PSYCHOLOGY	Depression	☐	☐	☐	Anxiety or panic	☐	☐	☐

If you have any pain and related condition(s), please check the appropriate boxes below and mark on the figure.

Location of Pain	Level (1-10)	Constant/ intermittent	Stabbing	Heavy	Sore	Dull	Burning	Numb/ Tingling	Spasms	Weakness
Headache		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Jaw		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Upper back		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Middle back		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Lower back		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Chest		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Neck		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Shoulders		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Upper Arm		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Elbows		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Forearm		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Wrists		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Hands		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Buttocks		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Hip		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Thighs		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Knees		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Legs		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Ankles		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Foot		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐

Please mark your conditions on the figure below
Pain: *X*, Spasm: S, Numbness: *N*, Weakness: W

Reviewed by: