



## ACUPUNCTURE INTAKE

Name: \_\_\_\_\_  
Street: \_\_\_\_\_ City, State \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
E-Mail Address (for appointment confirmations) \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Age: \_\_\_\_\_ Height: \_\_\_\_\_ Approx. blood pressure? \_\_\_\_\_ With Meds? \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

What is your chief complaint or reason(s) for this visit? \_\_\_\_\_

When did you first notice symptoms? \_\_\_\_\_

What improves the condition? \_\_\_\_\_

What worsens the condition? \_\_\_\_\_

What treatments have you tried? \_\_\_\_\_

Have you received Acupuncture treatments before? YES NO

Where? \_\_\_\_\_ When? \_\_\_\_\_

By whom? \_\_\_\_\_

Are you willing to take Chinese Herbs if so prescribed by your practitioner? YES NO

### REQUIRED

**Pursuant to the requirements of Section 6.11, Subsection (d) V. A. C. S., article 4495b, governing the practice of Acupuncture**

I, (patient's name), \_\_\_\_\_, am notifying Serasana, of the following:

YES NO NA I have been evaluated by a physician or dentist for the condition being treated within the six months before this acupuncture treatment was performed.

I recognize that Serasana is required to tell me: I **should** be evaluated by a physician for the condition being treated by the acupuncturist.

\_\_\_\_\_ (initials of patient)

Signature of Patient \_\_\_\_\_ Date: \_\_\_\_\_



# ACUPUNCTURE INTAKE

## PAST MEDICAL HISTORY

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> AIDS                | <input type="checkbox"/> Colitis/Bowel Disease      | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> HIV Positive       | <input type="checkbox"/> Tonsillitis      |
| <input type="checkbox"/> Eating Disorder     | <input type="checkbox"/> Malaria                    | <input type="checkbox"/> Typhoid Fever      | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Appendicitis        | <input type="checkbox"/> Elevated Liver Enzymes     | <input type="checkbox"/> Measles            | <input type="checkbox"/> Rheumatism       |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Mononucleosis              | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever    |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> Nephritis          | <input type="checkbox"/> Small Pox        |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Food, Chem, Drug Poisoning | <input type="checkbox"/> Stroke             | <input type="checkbox"/> Hernia           |
| <input type="checkbox"/> Bladder Disease     | <input type="checkbox"/> Gall Stones                | <input type="checkbox"/> Hepatitis (type?)  | <input type="checkbox"/> Heart Disease    |
| <input type="checkbox"/> Breast Lumps        | <input type="checkbox"/> Neuralgia                  | <input type="checkbox"/> Chronic Fatigue    | <input type="checkbox"/> Chicken Pox      |
| <input type="checkbox"/> Polio or Meningitis | <input type="checkbox"/> Goiter                     | <input type="checkbox"/> Candida            |   |
| <input type="checkbox"/> Bursitis            | <input type="checkbox"/> Gout                       | <input type="checkbox"/> Cancer _____       |   |

Other: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Significant Traumas (auto accidents, death of loved one): \_\_\_\_\_

Allergies (drugs, chemicals, foods, airborne): \_\_\_\_\_

Medications taken in the last month (include vitamins, over-the-counter drugs, herbs,...): \_\_\_\_\_

## CURRENT MEDICAL INFORMATION (FOR PREVIOUS 3 MONTHS)

### GENERAL

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Fever  | <input type="checkbox"/> Chills             | <input type="checkbox"/> Cravings (what?) |
| <input type="checkbox"/> Insomnia   | <input type="checkbox"/> Excessive dreaming | <input type="checkbox"/> Feel cold often  |
| <input type="checkbox"/> Bleed or bruise easily                             | <input type="checkbox"/> Disturbing dreams  | <input type="checkbox"/> Feel hot often   |
| <input type="checkbox"/> Excessive antibiotic use (episodes per year _____) |   |   |

### SKIN AND HAIR

- |                                       |                                 |   |
|---------------------------------------|---------------------------------|---|
| <input type="checkbox"/> Rashes       | <input type="checkbox"/> Acne   | <input type="checkbox"/> Hives          |
| <input type="checkbox"/> Itching      | <input type="checkbox"/> Eczema | <input type="checkbox"/> Recent moles   |
| <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Boils  | <input type="checkbox"/> Premature gray |

Other: \_\_\_\_\_

### HEAD, EYES, EARS, NOSE, AND THROAT

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Dizziness                         | <input type="checkbox"/> Spots in front of eyes  | <input type="checkbox"/> Headaches (chronic?) |
| <input type="checkbox"/> Recent change in vision           | <input type="checkbox"/> Night blindness         | <input type="checkbox"/> Migraine             |
| <input type="checkbox"/> Blurry vision                     | <input type="checkbox"/> Eye pain                | <input type="checkbox"/> Grinding teeth       |
| <input type="checkbox"/> Poor hearing                      | <input type="checkbox"/> Dry eyes                | <input type="checkbox"/> Jaw clicks           |
| <input type="checkbox"/> Recurrent sore throats            | <input type="checkbox"/> Red & itchy eyes        | <input type="checkbox"/> Earaches             |
| <input type="checkbox"/> Sinus problems (acute or chronic) | <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Facial pain          |
| <input type="checkbox"/> Runny nose                        | <input type="checkbox"/> Sneezing                | <input type="checkbox"/> Nasal congestion     |
| <input type="checkbox"/> Gum problems                      | <input type="checkbox"/> Nose bleeds             |   |

Other: \_\_\_\_\_

## ACUPUNCTURE INTAKE

### GASTROINTESTINAL

- |                                     |                                      |   |                                       |
|-------------------------------------|--------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Nausea     | <input type="checkbox"/> Vomiting    | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Gas        | <input type="checkbox"/> Diarrhea    | <input type="checkbox"/> Abdominal cramps     | <input type="checkbox"/> Indigestion  |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Belching             |                                       |

Other: \_\_\_\_\_

### GENITO-URINARY

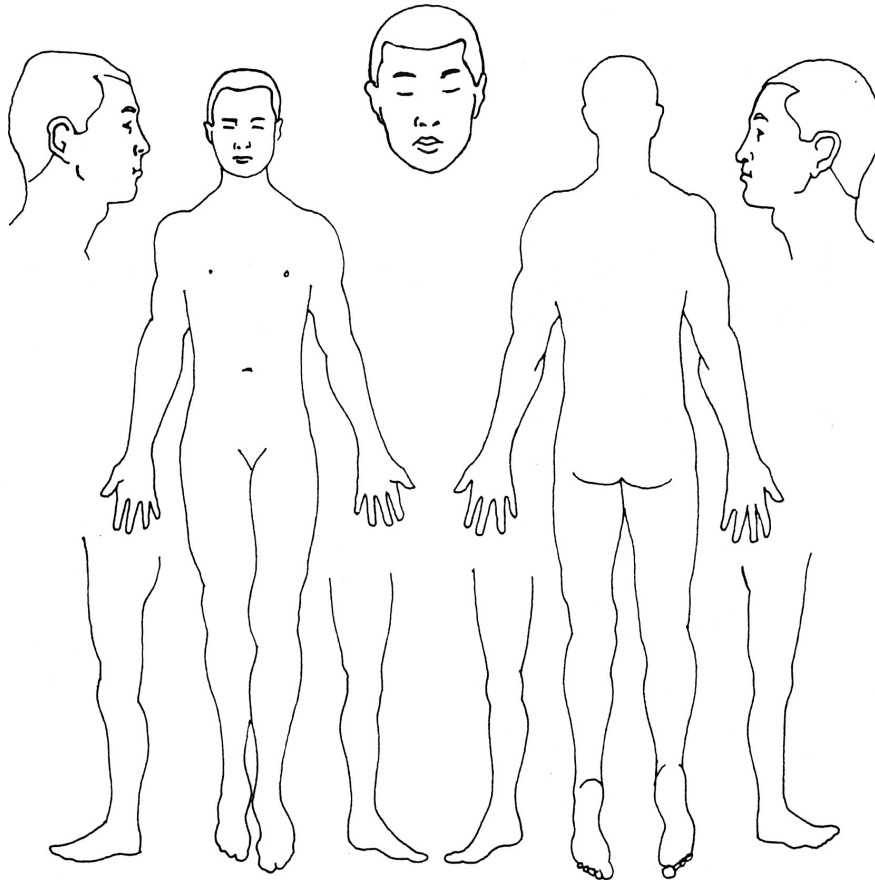
- |   |                                    |  |
|---|------------------------------------|--|
| <input type="checkbox"/> Prostate problems                          | <input type="checkbox"/> Impotence | <input type="checkbox"/> Urinary Tract Infections (chronic or acute) |
| <input type="checkbox"/> Herpes (outbreaks how often?) Other: _____ |                                    |  |

### MUSCULOSKELETAL

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Neck pain                             | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Hip pain        |
| <input type="checkbox"/> Back pain                             | <input type="checkbox"/> Muscle pain     | <input type="checkbox"/> Shoulder pain   | <input type="checkbox"/> Elbow pain      |
| <input type="checkbox"/> Back pain (radiates down back of leg) |  | <input type="checkbox"/> Knee pain       | <input type="checkbox"/> Cortisone shots |
| <input type="checkbox"/> Back pain (radiates down side of leg) |  | <input type="checkbox"/> Foot/ankle pain |  |

Other: \_\_\_\_\_

### PLEASE MARK PAINFUL OR DISTRESSED AREAS





## ACUPUNCTURE INTAKE

### CARDIOVASCULAR

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain                      |
| <input type="checkbox"/> Irregular heartbeat    | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Palpitations                    |
| <input type="checkbox"/> Cold hands and/or feet | <input type="checkbox"/> Swelling of hands  | <input type="checkbox"/> Fainting                        |
| <input type="checkbox"/> Blood clots            | <input type="checkbox"/> Swelling of feet   | <input type="checkbox"/> Diagnosed mitral valve prolapse |

Other: \_\_\_\_\_

### RESPIRATORY

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Cough (dry or productive)            | <input type="checkbox"/> Coughing blood        | <input type="checkbox"/> Production of phlegm (color? _____) |
| <input type="checkbox"/> Bronchitis (acute or chronic?)       | <input type="checkbox"/> Pain with deep breath | <input type="checkbox"/> Pneumonia                           |
| <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> Asthma                |  |

Other: \_\_\_\_\_

### NEUROPSYCHOLOGICAL

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Seizures          | <input type="checkbox"/> Cry often            | <input type="checkbox"/> Anxiety         |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Stress          |
| <input type="checkbox"/> Concussion        | <input type="checkbox"/> Depression           | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Bad temper        | <input type="checkbox"/> Considered suicide   | <input type="checkbox"/> Poor memory     |
| <input type="checkbox"/> Worry             | <input type="checkbox"/> In therapy now       | <input type="checkbox"/> Mania           |
| <input type="checkbox"/> Physically abused | <input type="checkbox"/> Emotionally abused   | <input type="checkbox"/> Sexually abused |

Hospitalized for emotional issues: \_\_\_\_\_

Do you feel you get adequate affection in your life? \_\_\_\_\_

Other: \_\_\_\_\_

### REPRODUCTIVE & GYNECOLOGICAL (Women Only)

- |   |   |   |
|---|---|---|
| _____ # of Pregnancies                                  | _____ # of Births                                 | _____ # of Miscarriages                                   |
| <input type="checkbox"/> Long periods (7 days or more)  | <input type="checkbox"/> Irregular periods        | <input type="checkbox"/> Vaginal discharge (color & odor) |
| <input type="checkbox"/> Short periods (3 days or less) | <input type="checkbox"/> Clotting                 | <input type="checkbox"/> Yeast infections                 |
| <input type="checkbox"/> Painful periods                | <input type="checkbox"/> PMS - breast distension  | <input type="checkbox"/> Menopausal symptoms              |
| <input type="checkbox"/> Painful ovulation              | <input type="checkbox"/> PMS - emotional symptoms | <input type="checkbox"/> Birth control (what type?)       |

Please let your practitioner know if there is any chance you may be pregnant today.  
Some acupuncture points and herbs are contraindicated during pregnancy.

Other: \_\_\_\_\_

### COMMENTS

Please tell me of any other issues you would like to discuss: \_\_\_\_\_

### Cancellation Policy

At Serasana, we all believe in respecting time. We will always do our best to prevent you from waiting before your appointments and/or having to change your appointments. We ask that, in return, you also respect our time. Please kindly give 24-hour notice if you need to change your appointment so another client can utilize that time slot. The Late Cancellation Fee is 50% of the service fee. Fees for "No Shows" equate to the full cost of the appointment missed.



# ACUPUNCTURE INTAKE

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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

**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 then be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall 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 the 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: \_\_\_\_\_



# ACUPUNCTURE INTAKE

## 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 on any unanticipated or unpleasant effect 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.

1. There is a slight chance that a bruise may appear at the site of the needle insertion. This is due to lightly brushing a blood vessel. The bruise should dissipate within a few days. Rub the area to keep the blood circulating. This may occur at some time during your course of treatments. There will be markings on your skin after gua sha and cupping. This are expected and will dissipate in 5 – 10 days.
2. Slight swelling may occur around the insertion site. The swelling will usually dissipate within 2 to 24 hours. This is just a skin reaction and happens very rarely.
3. Slight redness may appear around the site of insertion. This is usually due to an increase of blood circulation around the needle. This is fairly common and disappears after a couple minutes or hours.
4. If the needle brushes the sheath of a nerve, the area will be sore during and after that treatment for several days. This occurs rarely.
5. You may experience some light-headedness or dizziness after a treatment. This usually lasts only a few minutes. There is no hurry for you to leave. If you need to sit for a while, please feel free to do so in the lobby.
6. You may be slightly tired after a treatment, this is due to the deep relaxation state that is created. We ask that you take your time in getting up off the treatment table.

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.

<b>ACUPUNCTURIST NAME:</b> X	Date:
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<b>PATIENT SIGNATURE:</b> X	Date:
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(Or Patient Representative: \_\_\_\_\_, Indicate relationship if signing for patient: \_\_\_\_\_)