



IN HARMONY Wellness Center

This is a **CONFIDENTIAL** questionnaire to help us determine the best treatment plan for you. If you have questions, please ask. Thank you.

Personal Information

Name _____ Date _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Email _____ Work Phone _____

Occupation _____ Person Responsible for your account _____

Emergency Contact: Name _____ Phone _____

Who should we thank for referring you to this office? _____

Sex: Male Female Trans ___MTF___FTM Height _____ Weight _____ Birthdate _____ Age _____

Marital Status: Married Single Divorced Widowed Partnered Number of children _____

Have you received acupuncture therapy before? Yes No

When? _____ With whom? _____

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had:

Illness	You	Your Relative	Approx. Date	Illness	You	Your Relative	Approx. Date
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sexually Transmitted Diseases: <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> HIV <input type="checkbox"/> HPV <input type="checkbox"/> Chlamydia <input type="checkbox"/> Herpes				Date _____			

List any medications and supplements your are currently taking: (Continue on back if necessary.)

Medicine	Dosage	Reason	How long	Prescribed by	Date of last checkup

Check the Box if any of the following statements are true:

- I have known allergies
- I have a pacemaker
- I am taking Coumadin/warfarin
- I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs)

Please indicate the use and frequency of the following:

	Yes	No	How much		Yes	No	How much		Yes	No	How much
Coffee/black tea	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____	Water Intake	<input type="checkbox"/>	<input type="checkbox"/>	_____
Non-medical drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Soda pop	<input type="checkbox"/>	<input type="checkbox"/>	_____

OB/GYN History

Age of 1st period (menarche) _____ Are you pregnant? Yes No # of pregnancies _____

Age of last period (menopause) _____ # of live births _____ # Abortions _____ # of Miscarriages _____

Number of days between periods _____ Date of last: Gynecologic exam _____ Pap Smear _____

Number of days of flow _____ Mammogram _____ Bone Density Scan _____

Color of flow _____ Results _____

Clots? Yes No Color _____

Average number of pads you use per day: 1st day _____ 2nd day _____ 3rd day _____ 4th day _____ + days _____

Have you been diagnosed with: Fibroids Fibrocystic Breasts Endometriosis Ovarian Cysts PID Other _____

Location of Pain: Lower abdomen Lower back Thighs Other _____

Nature of Pain (Please indicate before, during or after menses) Other Symptoms related to menses:

Cramping _____ Stabbing _____ Discharge Vaginal dryness Headache

Burning _____ Aching _____ Nausea Constipation Diarrhea

Dull _____ Bloating _____ Swollen breasts Mood swings Ravenous appetite

Consistent _____ Intermittent _____ Poor appetite Hot flashes Night sweats

Bearing down sensation _____ Increased libido Decreased libido Insomnia

Urogenital History

Date of last prostate check up _____ PSA results _____ Manual prostate exam results _____

Lab results _____

Frequency of Urination: daytime _____ nighttime _____ Color of urine: clear murky odor: _____

Symptoms related to prostate

prostate problems Delayed stream Post void dribbling Incontinence Retention of Urine

Erectile dysfunction (ed) Increased libido Decreased libido Premature ejaculation Impotence

Back pain Groin pain Testicular pain Decreased force of stream BPH/Enlarged prostate

other _____

Symptom Survey

*The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
no mark () = never experience check mark (a) = sometimes experience plus sign (+) = frequently experience*

<p>___ lack of appetite</p> <p>___ excessive appetite</p> <p>___ loose stool or diarrhea</p> <p>___ digestive problems, indigestion</p> <p>___ vomiting</p> <p>___ belching, burping</p> <p>___ heartburn/reflux</p> <p>___ feeling the retention of food in the stomach</p> <p>___ tendency to become obsessive in work, relationships...</p> <hr/> <p>___ insomnia, difficulty sleeping</p> <p>___ heart palpitations</p> <p>___ cold hands and feet</p> <p>___ nightmares</p> <p>___ mentally restless</p> <p>___ laughing for no apparent reason</p> <p>___ angina pains</p>	<p>___ abdominal pain</p> <p>___ chest pain</p> <p>___ sciatic pain</p> <p>___ headaches</p> <p>___ pain or coldness in the genital area</p> <hr/> <p>___ cough</p> <p>___ shortness of breath</p> <p>___ decreased sense of smell</p> <p>___ nasal problems</p> <p>___ skin problems</p> <p>___ feeling of claustrophobia</p> <p>___ bronchitis</p> <p>___ colitis or diverticulitis</p> <p>___ constipation</p> <p>___ hemorrhoids</p> <p>___ recent use of antibiotics</p>	<p>___ eye problems</p> <p>___ jaundice (yellowish eyes or skin)</p> <p>___ difficulty digesting oily foods</p> <p>___ gall stones</p> <p>___ light colored stool</p> <p>___ soft or brittle nails</p> <p>___ easily angered or agitated</p> <p>___ difficulty in making plans or decisions</p> <p>___ spasms or twitching of muscles</p> <hr/> <p>___ low back pain</p> <p>___ knee problems</p> <p>___ hearing impairment</p> <p>___ ear ringing</p> <p>___ kidney stones</p> <p>___ decreased sex drive</p> <p>___ hair loss</p> <p>___ urinary problems</p>	<p>___ fatigue</p> <p>___ edema</p> <p>___ blood in stool</p> <p>___ black tarry stool</p> <p>___ easily bruised</p> <p>___ difficult to stop bleeding</p> <p>___ asthma</p> <p>___ tendency to catch colds easily</p> <p>___ intolerance to weather changes</p> <p>___ allergies</p> <p>___ hay fever</p> <p>___ dizziness</p> <p>___ tendency to faint easily</p> <p>___ high cholesterol levels</p> <p>___ sudden weight loss</p>
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In Harmony Acupuncture & Healing Clinic
619-675-1293

Cancellation Policy

Thank you for choosing In Harmony Acupuncture & Healing clinic. Please contact us at least 24 hours to cancel or reschedule your appointment. We enforce a strict cancellation policy and you will be charged the full amount for your scheduled appointment time if cancellation or rescheduling is less than 24 hours. Thank you for your time and understanding.

I _____ (please print name), have read the above policy and acknowledge that I will be charged the full amount and am responsible for payment of my scheduled appointment if I cancel or reschedule with less than 24 hours notice.

Signed(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 California 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 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 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 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**

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 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 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.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE

X

(Or Patient Representative)

(Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE