Corvallis Acupuncture & Wellness Center, LLC
107 SW 2nd St. Corvallis, OR 97333
corvallisacupuncture.com
(541) 602-8172

PATIENT CONFIDENTIAL INFORMATION

Date _____ Name _____

Date of Birth _____ Age _____ Sex M F Marital Status M S D W

Preferred Pronoun she/her him/his they/them other _____

Occupation _____ Do you enjoy your work? Y N

Email _____ Phone _____ Cell _____

Street Address _____

City _____ State _____ Zipcode _____

If we need to get in contact with you, may we contact you by: Phone Email By Mail

Emergency Contact _____ Phone _____

How did you hear about Corvallis Acupuncture & Wellness Center?
_____
_____
_____

CASE HISTORY

What are your primary health concerns?
_____
_____
_____

Please list secondary health concerns you may have
_____
_____
_____

Is your health concern(*s*) a result of: Auto Accident Injury Job Related Other

Date of Accident/Injury (*if applicable*) _____

Have you seen any other health care providers about this/these conditions? Y N

If Yes, who? _____

May we contact them? Y N

Who is your current primary health care provider? _____

Clinic name _____ May we contact them? Y N

Date of last physical _____ Height _____ Weight _____ Weight (*1yr ago*) _____

For Females: Are you pregnant? Y N If yes, how far along are you? _____
Please note that if you do become pregnant, it is important to tell me at your next appointment.

For Minors: Please provide both parents' names and address
_____
_____

INSURANCE INFORMATION

Do you have a person, group health or accident insurance? Y N If yes, please provide:

Health Insurance Company _____

Address _____

Subscriber Name _____ Phone _____

Group Number _____ ID Number _____

I have read the above information and certify it to be true to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes for my care and health management.

Date _____ Signature _____

PERSONAL HEALTH HISTORY

Check the appropriate line if you have experienced any of the following:

___ Adverse reaction to medical treatment

___ Allergies: Seasonal Environmental Food

___ Anemia

___ Arthritis

___ Bleeding Disorder

___ Cancer or Tumor

___ Chemical Dependency

___ Diabetes

___ Eating Disorder

___ Gout

___ Headaches

___ Heart Disease

___ Hepatitis or Liver Disorder

___ Herpes

___ High Blood Pressure

___ Hernia

___ Immune Disorder

___ Other: _____

___ Intestinal Disorder

___ Kidney Disorder

___ Low Blood Pressure

___ Musculo-Skeletal Disorder

___ Organ Transplant

___ Pacemaker

___ Respiratory Disorder

___ Sciatica

___ Seizures/Epilepsy

___ Skin Disorder

___ Specialized Diet

___ Stroke

___ Thyroid Disease

___ Tuberculosis

___ Ulcer

___ Urinary Tract Disorder

___ Venereal Disease

Is there anything else we should know about your medical history?

_____
_____
_____

Major hospitalizations: If you have been hospitalized for any serious medical illness or surgery, please describe it below. Do not include normal pregnancies.

_____
_____
_____
_____
_____
_____

Medication and Supplements: Please list all over the counter medications, prescriptions, vitamins, herbs, etc. that you are currently taking.

_____
_____
_____
_____
_____
_____

Please list any allergies to medication.

_____
_____
_____

Previous Pregnancies

Year Length of Pregnancy Labor Hours Type of Delivery

_____
Complications?_____

_____
Complications?_____

_____
Complications?_____

_____

Complications?_____

_____

Complications?_____

Lifestyle

Use of tobacco: Y N If yes, how many cigarettes per day _____ Age started _____

Use of alcohol: Y N If yes, how many drinks per week? _____ Age started _____

Use of caffeine: Y N # soda/day _____ # coffee/day _____ # tea/day _____

Use of marijuana: Y N Frequency _____ Age started _____

Other Drug Use? _____

Are you concerned about the use of any of the above lifestyle choices and/or interested in quitting or cutting back?

_____

_____

Diet

What sort of diet do you have? (*please check all that apply*)

___ Standard American ___ Weight Loss ___ Fast/Quick Prep

___ Vegetarian ___ Vegan ___ Raw Food

___ Low Fat ___ Low Carb ___ Muscle Building

___ Balanced Food Groups

Please list foods and beverages that you consume in a normal week

Breakast	Snack	Lunch	Snack	Dinner	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

How many glasses of water do you drink per day? _____

Water intake: Cold Room temperature

Is nutrition or diet something you'd like to improve or be evaluated for? Y N

Activity & Exercise

What type of exercise do you do? _____ For how long? _____

How many times per week? _____

Activity level at work _____ Activity level at home _____

Would you like an evaluation for the best for of exercise for your body and health? Y N

Mental Health

How would you characterize your life in terms of stress?

___ High Stress ___ Much Stress ___ Fairly Stressed

___ Mild Stress ___ Periodic Stress ___ No Stress

Would you like to be handling stress better, or reduce the effects of stress? Y N

Do you currently experience any of the following moods often?

___ Depression ___ Anxiety ___ Insecurity

___ Anger ___ Irritability ___ Phobias

___ Nervous ___ Sadness ___ Mood Swings

___ Short Temper ___ Obsessive Thinking ___ Isolated

___ Hopelessness ___ Thoughts of Suicide

Would you like to be evaluated for possible treatment solutions for these states? Y N

Please check off symptoms you have had in the <u>past month</u>.

Health, Part A

___ Cough ___ Allergies ___ Nasal Congestion

___ Sore Throat ___ Itchy Eyes ___ Sinus Congestion

___ Hoarseness ___ Sneezing ___ Sinus Pain

___ Frequent Colds/Flu ___ Nasal Discharge ___ Shortness of Breath

___ Swollen Glands ___ Wheezing ___ Chest Tightness

___ Painful Lymph Nodes ___ Grief/Sadness ___ Crave Spicy Food

___ Skin Rashes ___ Acne ___ Fever/Chills

___ Spontaneous Sweating

Health, Part B

For the following symptoms, indicate with a letter, if daily (D), weekly (W) or monthly (M)

___ Nausea # of Bowel Movements Per Day _____

___ Vomiting ___ Loose Stools ___ Slow Wound Healing

___ Bloating ___ Hard Stools ___ Frequently Fatigued

___ Gas ___ Painful Stools Time of Day You're Fatigued ___

___ Belching ___ Blood or Mucus Stools ___ Organ Prolapse

___ Acid Regurgitation ___ Difficulty Passing Stools ___ Loss of Taste

___ Stomach Pain ___ Odorous Stools ___ Crave Sweets

___ Ulcers ___ Burning Stools ___ Crave Carbohydrates

___ Bad Breath ___ Alt Diarrhea/Constipation ___ Heavy Limbs

___ Gum Bleeding ___ Hemorrhoids ___ Weak Muscles

___ Excessive Hunger
___ Fatigue After Eating
___ Easily Worried
___ Poor Appetite
___ Recent Weight Gain
___ Edema/Retaining Water
___ Bruise Easily
___ Recent Weight Loss
___ Varicose/Spider Veins
___ Foggy-Headed

Health, Part C

___ Irritability
___ Dizziness
___ Eye Pain/Strain
___ Frustration
___ Vertigo
___ Neck/Shoulder Pain
___ Easily Stressed
___ Dry Hair/Skin/Nails
___ Tremors
___ Frequent Angry Outbursts
___ Dry Eyes/Floaters
___ Blurry Vision
___ Rib/Side Pain
___ Red Eyes
___ Hiccups
___ Frequent Sighing
___ Bitter Taste in Mouth
___ Sensation of Something in the Throat

Health, Part D

___ Low Back Pain
___ Scanty Urination
___ Fear/Phobias
___ Poor Hearing
___ Urgent Urination
___ Lack of Will/Drive
___ Ear Ringing
___ Profuse Urination
___ Crave Salt
___ Hair Loss
___ Discolored Urination
___ Swollen Ankles
___ Premature Graying
___ Dribbling Urination
___ Birth Defects
___ Cold Hands/Feet
___ Frequent Urination
___ Generalized Cold Feeling
___ Warm Body Temperature
___ Nighttime Urination
___ Osteoporosis
___ Knee Pain
___ High/Low Libido
___ Dark Circles Under Eyes

___ Puffy Under Eyes ___ Developmental Problems in Childhood

Health, Part E

___ Palpitations ___ Thirst ___ Anxiety

___ Difficulty Falling Asleep ___ Dry Mouth/Throat ___ Depression

___ Wake During the Night ___ Sore Tongue ___ Restless

___ Disturbing Dreams ___ Poor Memory ___ Night Sweats

___ Jittery/Easily Startled

Men

Last Prostate Exam _____ PSA Results _____

___ Prostatitis/BPH ___ Low Sperm Progression

___ Premature Ejaculation ___ Low Sperm Count ___ Difficulty Achieving Erection

___ Poor Sperm Mobility

Women

First day of your last period _____ # of days of bleeding _____

Length of total cycle _____ # of pads/tampons per day _____

Color of Blood: ___ Pale ___ Purple ___ Bright Red ___ Dark Red ___ Brown

Clots: ___ Large ___ Small ___ Purple ___ Red ___ Brown

# of Pregnancies _____ # of Live Births _____ Age of Menarche _____

Age of Menopause _____

GYN Surgeries (*date/type*) _____

Are you taking birth control? Y N If yes, what type of birth control? _____

___ Infertility ___ Fibroids ___ Cramping

___ Mood Swings ___ Breast Tenderness ___ Food Cravings

___ Headaches w/ Period ___ Bleeding b/t Periods ___ Regular Breast Exams

___ Breast Lump/Fibrocystic ___ Pregnant ___ Nursing

___ Abnormal Pap Test ___ Pain with Intercourse ___ Abnormal Vaginal Discharge

___ Hot Flashes

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Name _____

Birth Date _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

Patient Signature _____ Date _____
(*or Patient Representative*) (*indicate relationship if signing for patient*)

Office Signature _____ Title _____ Date _____

Accepted Denied

24 HOUR CANCELLATION & “NO SHOW” FEE POLICY

Recognizing that everyone’s time is valuable and the appointment time is limited, we ask that you provide a 24 hour notice if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Corvallis Acupuncture & Wellness Center reserves the right to charge a fee of $45.00 for the first appointment missed and $90 each missed (”No Show”) appointment thereafter, which is not absent for a compelling reason, and is not cancelled within a 24 hour advance notice.

“No Show” fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. We will send you a text and email reminder of each appointment (when we have your phone or email address) but it is still your responsibility to check emails, junk mail and text messages. Thank you for your cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy.

Patient Signature _____ Date _____

Policy Effective: January 2019

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 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

AAC-FED

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.

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.

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:

(Date)

PATIENT SIGNATURE X

(Or Patient Representative)

(Indicate relationship if signing for patient)

ALSO **SIGN** THE **ARBITRATION AGREEMENT** ON **REVERSE** SIDE

AAC-FED