Smart Acupuncture | Dave Smart, L.Ac.

Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____

Date of Birth: _____ Gender: _____

Marital Status: _____ Number of Children: _____

Address: _____

_____

Day Phone: _____ Evening Phone: _____

Email: _____ Cell Phone: _____

Preferred Method of Contact: _____

Primary Care Physician: _____ Number: _____

Occupation: _____

Employer's Name: _____ Number: _____

Employer's Address: _____

Social Security Number: _____

In Case of Emergency:

Contact Name: _____ Number: _____

Relationship: _____

1. What are your health concerns that you would like to address?

_____

_____

Are any of these adversely affecting your quality of life?

_____

2. Please list any foods, drugs, or medications you are hypersensitive to or and allergies you may have (please include reaction):

_____

_____

_____

3. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

_____

_____

4. Do you have any infectious diseases? Y N
If yes, please identify: _____

5. Childhood Illness (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps

Measles German Measles Chicken Pox Strep Throat

6. Hospitalizations and Surgeries

Reason When

_____

_____

_____

_____

7. Emotional (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension

Anxiety Depression Bipolar Disorders

Other: _____

8. Energy and Immunity (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

Other: _____

9. Head, Eye, Ear, Nose, and Throat (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Hay Fever

Glasses/Contacts Tearing/Dryness Impaired Hearing Ear Ringing

Earaches Headaches Sinus Problems Nose Bleeds

Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems

10. Respiratory (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing

Asthma Emphysema Persistent Cough Pleurisy

Tuberculosis Shortness of Breath

11. Cardiovascular (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Arrhythmia Myocardial Infraction Stroke

Heart Murmurs Rheumatic Fever Varicose Veins

12. Gastrointestinal (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Changes in Bowel Habits Nausea/Vomiting

Constipation Diarrhea Epigastric Pain Passing Gas

Heartburn Belching Hemorrhoids Abdominal Pain

Gall Bladder Disease Liver Disease Hepatitis B or C

13. Genito-Urinary Tract (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Painful/Impaired Urination Frequent UTI Blood in Urine

Frequent Urination/At Night Heavy Urinary Flow Kidney/Bladder Stones

14. Female Reproductive/Anatomy (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge

Heavy Flow Vaginal Discharge Premenstrual Problems

Clotting Bleeding Between Cycles Painful Periods

Menopausal Symptoms Difficulty Conceiving

15. Menstrual/Birth History
Do you have any reason to believe you may be pregnant? Y N
If so, how far along are you?

Age of First Menses: _____ Number of Days of Flow: _____
Length of Cycle: _____ Quality of Flow: _____
Number of Pregnancies: _____ Number of Live Births: _____
Number of Miscarriages: _____ Number of Abortions: _____

16. Male Reproductive (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostate Problems Testicular Pain/Swelling

Penile Discharge Nocturnal Emissions

17. Musculoskeletal (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Joint Pain Muscle Spasms/Cramps Arm Pain/Leg Pain

Upper Back Pain Mid Back Pain Low Back Pain

What is the quality of the pain? _____

Is there anything that makes it better?_____ Worse?_____

18. Neurologic (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling

Loss of Balance Seizures/Epilepsy

19. Endocrine (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid

Diabetes Mellitus Night Sweats Feeling Hot or Cold

20. Sleep

How many hours a night are you sleeping? _____

What is the Quality of your sleep? _____

21. Lifestyle

Do you smoke cigarettes? _____ How many per day? _____

What is your caffeine consumption? _____

Do you drink alcohol? _____ Number of drinks/week _____

Please list any recreational drugs: _____

What is your exercise routine? _____

22. Other (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

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 named 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, Tiu-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. 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 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.

PATIENT SIGNATURE **X**

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

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 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.

PATIENT SIGNATURE	X	
(Or Patient Representative)		(Indicate relationship if signing for patient)
OFFICE SIGNATURE	X	

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE