WellnessOne of Redding
It's your future... be there healthy with WellnessOne™

Confidential Acupuncture Patient Information

Your privacy is important to use. We comply with all Health Information Patient Protection Act rules, regulations and laws. Our HIPPA Compliance Manual is available for your review.

Last Name: First Name: Initial:

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 (✓) = sometimes experience
plus sign (+) = frequently experience

- ☐ Lack of appetite
- ☐ Excessive appetite
- ☐ Loose stool or diarrhea
- ☐ Digestive problems, indigestion
- ☐ Vomiting
- ☐ Belching, burping
- ☐ Heartburn/Reflux
- ☐ Feeling the retention of food in the stomach
- ☐ Tendency to become obsessive in work, relationships…
- ☐ Insomnia, difficulty sleeping
- ☐ Heart palpitations
- ☐ Cold hands and feet
- ☐ Nightmares
- ☐ Mentally restless
- ☐ Laughing for no apparent reason
- ☐ Angina pains
- ☐ Abdominal pain
- ☐ Chest pain
- ☐ Sciatic pain
- ☐ Headaches
- ☐ Pain or coldness in the genital area
- ☐ Cough
- ☐ Shortness of breath
- ☐ Decreased sense of smell
- ☐ Nasal problems
- ☐ Skin problems
- ☐ Feeling of claustrophobia
- ☐ Bronchitis
- ☐ Colitis or diverticulitis
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Recent use of antibiotics
- ☐ Eye problems
- ☐ Jaundice (yellowish eyes or skin)
- ☐ Difficulty digesting oily foods
- ☐ Gall stones
- ☐ Light colored stool
- ☐ Soft or brittle nails
- ☐ Easily angered or agitated
- ☐ Difficulty in making plans or decisions
- ☐ Spasms or twitching of muscles
- ☐ Low back pain
- ☐ Knee problems
- ☐ Hearing impairment
- ☐ Ear ringing
- ☐ Kidney stones
- ☐ Decreased sex drive
- ☐ Hair loss
- ☐ Urinary problems
- ☐ Fatigue
- ☐ Edema
- ☐ Blood in stool
- ☐ Black tarry stool
- ☐ Easily bruised
- ☐ Difficult to stop bleeding
- ☐ Asthma
- ☐ Tendency to catch colds easily
- ☐ Intolerance to weather changes
- ☐ Allergies
- ☐ Hay fever
- ☐ Dizziness
- ☐ Tendency to faint easily
- ☐ High cholesterol levels
- ☐ Sudden weight loss

Notes or Additional Comments:

[Please continue on Page 2. Thank you.]

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

Illness	You	Your Relative	Approximate Date
Cancer	☐	☐	.....
Hepatitis	☐	☐	.....
High Blood Pressure	☐	☐	.....
Rheumatic Fever	☐	☐	.....
Infectious Diseases	☐	☐	.....
Diabetes	☐	☐	.....
Heart Disease	☐	☐	.....
Seizures	☐	☐	.....
Emotional Disorders	☐	☐	.....
Tuberculosis	☐	☐	.....

Sexually Transmitted Diseases: ☐ Gonorrhea ☐ HIV ☐ Chlamydia ☐ Herpes Date .....

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

☐ I have known allergies ☐ I am taking Coumadin/Warfarin
☐ I have a pacemaker ☐ I am taking Lithium [Eskalith, Lithobid, Lithonate, Lithotabs]

Please indicate the use and frequency of the following:

	Yes	No	How often/much?
Coffee/black tea	☐	☐	.....
Non-medical drugs	☐	☐	.....
Tobacco	☐	☐	.....
Alcohol	☐	☐	.....
Water Intake	☐	☐	.....
Soda	☐	☐	.....

OB/GYN History

Age of 1st period [menarche] ..... Are you pregnant? ☐ Yes ☐ No # of pregnancies .....
Age of last period [menopause] ..... # of live births ..... # Abortions ..... # 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]
Cramping ..... Stabbing .....
Burning ..... Aching .....
Dull ..... Bloating .....
Consistent ..... Intermittent .....
Bearing down sensation: .....

Other Symptoms related to menses:

- ☐ Discharge
- ☐ Vaginal dryness
- ☐ Headache
- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Swollen breasts
- ☐ Mood swings
- ☐ Ravenous appetite
- ☐ Poor appetite
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Increased libido
- ☐ Decreased libido
- ☐ Insomnia
- ☐ Other .....

Urogenital History

Date of last prostate check .....
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
- ☐ BPH/Enlarged prostrate
- ☐ decreased force of stream

☐ Other .....

How do you FEEL about the following areas of your life?
Please check the appropriate boxes and indicated any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Your Comments
Significant Other	☐	☐	☐	☐	☐	.....
Family	☐	☐	☐	☐	☐	.....
Diet	☐	☐	☐	☐	☐	.....
Sex	☐	☐	☐	☐	☐	.....
Self	☐	☐	☐	☐	☐	.....
Work	☐	☐	☐	☐	☐	.....
Exercise	☐	☐	☐	☐	☐	.....
Spirituality	☐	☐	☐	☐	☐	.....

Other information you would like to share which may be relevant to your medical history?

Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or the patient named below, for whom I am legally responsible) by WellnessOne of Redding's L.Ac. named below and/or other licensed acupuncturists who now or in the future treat me while working or associated with, or serving as a back-up for the WellnessOne of Redding acupuncturist named below, including those working at WellnessOne of Redding or any other office, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, exercise therapy Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the WellnessOne of Redding acupuncturist below uses sterile disposable and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. 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, mineral, and animal 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 understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the WellnessOne of Redding acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then know, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this 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 for to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Print Name of Patient	Print Name of Acupuncturist
Signature of Patient (or Representative)	Signature of Acupuncturist
(Print Name of Patient Representative)	(Print Name of Witness/Translator)
Date Consent Completed	(Signature of Witness/Translator)

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 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, 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 and shall decide the arbitration. Each party to 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 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 or limitation, 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.

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PATIENT SIGNATURE: DATE:
(*Or Patient Representative)

*To be completed by patient's representative if the patient is a minor or is physically or legally incapacitated. Indicate relationship if signing for patient.

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OFFICE SIGNATURE: DATE: