Path to Vitality Acupuncture

www.pathtovitalityacu.com Michelle Snyder, L.Ac.

Patient Initial Health History Form

Patient Information

Name: _____ Date: ____/_____/_____

Address: _____ Email: _____

Home Telephone: _____ Cell: _____

May we leave a message at these numbers? _____

Date of Birth: _____/ _____/ _____ Age: _____ Gender: M F T Other: _____

Married Partnered Divorced Widowed Single

Have you ever tried acupuncture/Chinese Medicine before? _____

How do you feel about receiving an acupuncture/Chinese Medicine treatment? _____

Please tell us who you were referred by so we may thank them: _____

Employment Status

Occupation: _____ Employer Name: _____

Emergency Contact Information

Emergency Contact Name & Relationship: _____

Telephone: _____

Primary Healthcare Provider

Physician or Clinic Name: _____ Telephone: _____

What are you currently being treated for? _____

About Your Health

What is the primary health concern for your visit today? _____

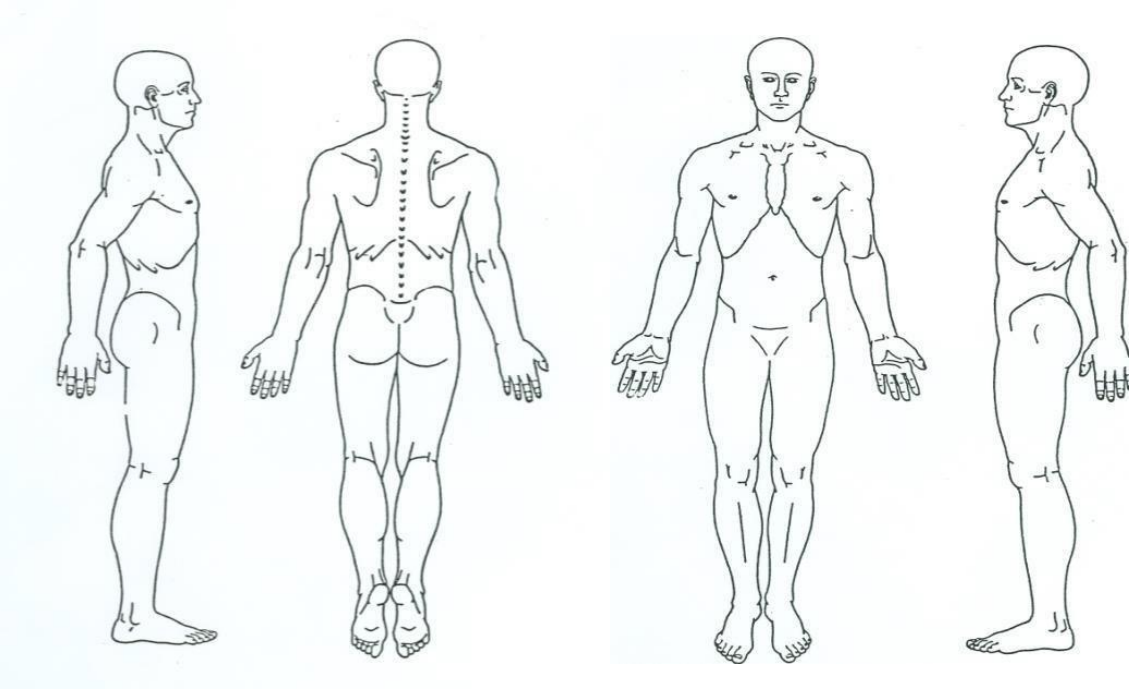
Was there a triggering event? _____

How long have you had the problem? _____

What treatments have you tried? _____

What makes it better or worse? _____

If you are currently experiencing physical discomfort, rate the level of your discomfort (**1**=least amount of pain/discomfort; **10**=worse pain/discomfort you have ever felt) _____



Using the figure above, please place the letter of the description on the area of discomfort:
N=Numbness **P**=Pins & Needles **B**=Burning **S**=Stabbing **A**=Aching **O**=Other

Please list any significant trauma or injuries you have had: _____

Hospitalizations and Surgeries

Operation/Procedure/Illness	Year

Exercise, Nutrition and Sleep

What type of exercise do you get and how often? _____

Please describe your typical diet:

Breakfast	
Morning snack	
Lunch	
Afternoon snack	
Dinner/Dessert	

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

Alcohol, tobacco or recreational drug use? _____

What is the quality of your sleep? _____ How many hours of sleep do you get? _____

Family History

Please list any major medical conditions and causes of death in immediate family.

Mother: _____

Father: _____

Siblings: _____

PATIENT MEDICATION & SUPPLEMENT LIST

Please include all prescribed & over the counter medications, herbs and supplements

Medication/Supplement Name	Prescribed By	Dosage/Frequency	Reason for Taking

MEDICAL HISTORY

Please indicate below if you **CURRENTLY** or **HAVE EVER HAD** any of the following:

Check	Condition	Date of Onset	Present Status
	Currently Pregnant		
	Bleeding Disorder		
	Epilepsy		
	Fainting spells		
	Pacemaker		
	Defibrillator		
	Heart Disease		
	Implants/Prosthetics		
	Cancer		
	Anemia		
	Blood clots (where?)		
	Compromised immunity / taking immune-		
	HIV/AIDS		
	Hepatitis (note A B C D or E)		
	Spinal fracture		
	Spinal cord injury		
	Sensory loss (where?)		

Please check the box next to the symptoms you are CURRENTLY experiencing

GENERAL

☐ Fever/chills ☐ Weakness/fatigue ☐ Insomnia ☐ Dream disturbed sleep

☐ Weight gain/loss ☐ Mania ☐ Obsessive thoughts/habits ☐ Depression

☐ Moodiness/Irritable ☐ Memory loss ☐ Panic attacks ☐ Difficulty concentrating

☐ Confusion ☐ Abnormal sweating ☐ Emotional changes ☐ Anxiety

☐ Feel refreshed upon waking (yes__/no__) ☐ General feeling of heaviness in the body

☐ Other: _____

CARDIOVASCULAR

☐ Chest pain w/exertion ☐ Irregular heartbeat ☐ Foot/ankle swelling

☐ Chest pain w/rest ☐ Shortness of breath ☐ Leg cramps/calf pain

☐ Chest pain that is new ☐ Cold/hot hands or feet ☐ High blood pressure

☐ Uncomfortable heartbeat ☐ Discolored hand/foot ☐ Low blood pressure

☐ Other: _____

RESPIRATORY

☐ Asthma ☐ Bronchitis ☐ Tuberculosis ☐ Wheezing

☐ Pneumonia ☐ Cough ☐ Emphysema ☐ Frequent colds/flu

☐ Bloody sputum ☐ Difficult/painful breathing ☐ Phlegm/mucus (what color? _____)

☐ Other: _____

GASTROINTESTINAL

☐ Nausea ☐ Ulcers ☐ Loss of appetite ☐ Vomiting

☐ Parasites ☐ Change in thirst ☐ Reflux ☐ Bad breath

☐ Diarrhea ☐ Belching ☐ Bad taste in mouth ☐ Loss of bowel control

☐ Trouble swallowing ☐ Urgent stool ☐ Black or bloody stool ☐ Feel tired after eating

☐ Hemorrhoids ☐ Liver disease ☐ Constipation ☐ Gall bladder disease

☐ Food sensitivities ☐ Abdominal pain, bloating or gas? Worse after meals? Yes___/No_____)

☐ Other: _____

GENITO-URINARY

☐ Burning urination ☐ Bloody urination ☐ Hesitant/dribbling urination ☐ Urinary tract infection

☐ Painful urination ☐ Decreased urine ☐ Increased urination ☐ Urinary incontinence

☐ Genital infection ☐ Kidney stones ☐ Normal color of urine (describe _____)

☐ Waking up to urinate (how often? _____) ☐ Other: _____

MUSCULOSKELETAL & NEUROLOGIC

☐ Muscle pain ☐ Paralysis ☐ Difficulty walking

☐ Joint or bone pain ☐ Numbness/tingling sensations ☐ Poor coordination/balance

☐ Nerve pain ☐ Tremors/involuntary movements ☐ Dislocations (list _____)

☐ Muscle cramps ☐ Limited range-of-motion ☐ Fractures (list _____)

☐ Muscle weakness ☐ Arthritis ☐ Osteopenia/Osteoporosis

Other: _____

HEAD/EYES/EARS/NOSE/THROAT/MOUTH

☐ Headache ☐ Ringing in ears ☐ Nosebleeds

☐ Dizziness/Vertigo ☐ Hearing loss ☐ Sinus problems

☐ Frequent ear infections ☐ Recurrent throat infections ☐ Mouth sores

☐ Head trauma ☐ Ear pain ☐ Bleeding/swollen/painful gums

☐ Vision changes (please describe): _____ ☐ Other: _____

☐ Rash ☐ New mole or growth ☐ Itchy skin ☐ Lumps

☐ Change in mole or growth ☐ Bruising ☐ Hair loss ☐ Sores

☐ Slow healing wounds ☐ Brittle nails ☐ Other: _____

ENDOCRINE

☐ Diabetes (Type I ____ or Type II ____) / Oral hypoglycemic ____ or Insulin ____

☐ Hypoglycemic ☐ Hyperthyroid ☐ Hypothyroid

☐ Parathyroid disorder ☐ Other: _____

☐ Frequent vaginal infections ☐ Painful menstrual periods ☐ Breast lumps

☐ Pain/itching of genitalia ☐ Irregular periods ☐ Premenstrual syndrome

☐ Genital lesions/discharge ☐ Bleeding between cycles ☐ Menopausal syndrome

☐ Abnormal pap smear ☐ Vaginal discharge ☐ Other: _____

MENSTRUAL HEALTH *(do not complete if you are in menopause)*

Age of first period: _____ Start date of last period: _____ Average number of days of flow: _____

Flow is: ☐ normal ☐ heavy ☐ light ☐ clotted

Color is (all that apply): ☐ normal ☐ dark-red ☐ bright-red ☐ light red-pink ☐ purple ☐ brown ☐ lt. brown

Date of last Pap test (cervical smear): _____ Diagnosed gynecological disorders / Other: _____

PREGNANCY HISTORY

Are you currently pregnant? ☐ Yes ☐ No If yes, how far along are you? _____

Are you currently trying to conceive? ☐ Yes ☐ No Are you experiencing difficulty conceiving? ☐ Yes ☐ No

Birth control? ☐ Yes ☐ No What type? _____

Total number of pregnancies: _____ Living ____ Ectopic ____ Miscarriages ____ Induced abortions____

MALES

☐ Pain/swelling of testicles ☐ Premature ejaculation ☐ Impotence ☐ Coldness/numbness in genitalia

☐ Other: _____

The above information regarding my medical history is, to the best of my knowledge, accurate and complete. I agree to promptly inform Michelle Snyder, L.Ac., of any changes in my health status.

Patient name (please print): _____

Patient signature: _____ Date: _____

Guardian signature: _____ Date: _____

PRIVACY PRACTICES / FINANCIAL AND OFFICE POLICIES

Please initial each box and sign below to indicate you have read and understand each section.

PRIVACY PRACTICES & PROTECTED HEALTH INFORMATION

☐ I have received Path To Vitality Acupuncture's *Notice of Privacy Practices* regarding my health information. **I authorize release of any information necessary to coordinate medical care**, including disclosure to other health care professionals for the purpose of evaluating my health, diagnosing medical conditions, providing treatment, and to secure payment for services rendered.

FINANCIAL POLICIES

☐ I assign any and all insurance benefits to Michelle Snyder, L.Ac., dba Path To Vitality Acupuncture. If my insurance carrier sends payment to me, I agree to send or bring those payments directly to this office upon receipt.

☐ I understand that all services rendered by this office are charged to me and that I am financially responsible for all charges, regardless of insurance coverage. For patients without insurance, payment is due on the date of service. For your convenience, we accept cash, personal checks and credit cards (including HSA and FSA credit cards).

☐ I have been advised to verify my benefits directly with my insurer. I have been informed that fees for treatment may not be covered by insurance.

☐ I understand that Path To Vitality Acupuncture (PTVA) verifies insurance benefits and bills insurance as a courtesy to the patient. PTVA is not financially responsible for benefit verification nor for collections from insurers. Claims submitted by PTVA and initially rejected by insurers will be re-billed a second time, after which unpaid claims will be billed directly to patient.

☐ I understand that a $20 fee will be assessed per bounced check.

☐ If my account is referred to a collections agency, I agree to pay reasonable collections expenses estimated at a minimum of $40 in addition to my full outstanding balance.

☐ I understand that if I suspend or terminate my care at any time, my portion of all charges for professional services is immediately due and payable to this office.

OFFICE POLICIES

☐ I understand that if I do not provide at least 24 hours advance notice of appointment cancellation or fail to show for a scheduled appointment, I will be charged $35 for a missed appointment. I am aware that insurance does not generally pay for missed appointments and that exception to these charges is solely at the discretion of Path To Vitality Acupuncture.

☐ I understand that three missed appointments without 24 hours prior notification may result in discharge from care and further scheduling is solely at discretion of the practitioner.

Patient signature _____ Date _____

Guardian 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. 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 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 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