Quantum Healing Therapies

General Information

First Name:_____Middle Initial:____Last Name: _____

Date of Birth:_____/_____/_____Age:_Sex:_____F M_____TG

Home Phone:_____Cell Phone: _____

Email address: _____

Address:_____City:_____State:_____Zip:_____

Marital Status:_____ Occupation:_____

Emergency Contact:_____Relationship:_____Phone:_____

Main complaint

Reason for seeking acupuncture? _____

When did I begin, or what was the initial cause? _____

Have you been given a diagnosis? If so, what? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

If you are experiencing pain, how would you rate it on a scale of 1- 10 _____

Would you describe your pain as: Sharp Cramping Fixed Burning Dull Aching

__ Moving Other: _____

Have you received previous treatment or care for this problem? If so what kind? _____

Are you currently receiving treatment of care? If so what kind and how often?

_____

Medical History

Surgeries: *please include reason and date* _____

Medications: (Please list all OTC, prescription, vitamins and supplements and what they are taken for.)

_____

Significant Trauma (auto accidents, falls, emotional etc): _____

Significant Childhood or Past Illnesses: _____

Allergies; seasonal, food, drug or contact: _____

Do you have or have you had an infectious disease? (HIV, TB, etc)_____Yes_____No

If so, please describe: _____

Current Health Conditions - *Check all that apply*

__Allergies
__Asthma
__ Alzheimer's
__ Blood Clotting Disorder
__ Cancer
__Diabetes Type I
__Diabetes Type II
__ Epilepsy / Seizures
__ Fibromyalgia
__ Heart Disease
__ High Cholesterol
__ Headaches / Migraines
__ Herniated Discs
__ Hypertension
__ Hypotension
__ Hypothyriodism
__ Hyperthyroidism
__ Kidney Disease
__ Kidney Stones
__ Metal Implants
__ Mental Illness
__ Multiple Sclerosis
__Osteoarthritis
__Rheumatoid Arthritis
__Parkinson's Disease
__ Pulmonary Disease
__ Stroke / TIA
__Other_____

Women's Health - *women only*

Age at first menses_____Duration of menses____Days between menses__ Date of last period_____Pregnant____Yes_____No Last Pap Smear_____
Number of pregnancies_____Number of births_____Miscarriages_____
Are you currently trying to conceive?____Yes____No

__Menstrual Pain
__Clotting
__Low back pain with menses
__Breast Tenderness
__Abnormal Vaginal Discharge
__Hot Flashes
__Heavy Bleeding
__Light Bleeding
__Normal Bleeding
__Mood Chang

ACUPUNCTURE INTAKE - *Check all that apply*

Heart
__Palpitations
__Anxiety
__Mental Confusion
__Chest Pain/Tightness
__Insomnia
__Forgetfulness
__Spontaneous Sweating
__ Restlessness Agitation
__ Craving Bitter Foods

Lung
__Nasal Discharge
__Sinus Congestion
__Dry Cough
__Cough with Phlegm
__Chronic Cough
__Dry Mouth
__Dry Throat
__Nose Bleeds
__Dry Nose
__Dry Skin
__Skin Rashes
__Itchy Skin
__Easily Catch Colds
__Sore Throat
__Difficulty Breathing
__Shortness of Breath
__Sadness
__ Craving spicy foods

Spleen / Stomach
__Poor Appetite
__Excess Appetite
__Abrupt Weight Loss
__ Abrupt Weight Gain
__Fatigue
__Bruise Easily
__Lack of Thirst
__Loose Stools
__Over Thinking
__Worrying
__Hemorrhoids
__Nausea/Vomiting
__Gas/Belching
__Bloating / Pain
__Edema/Swelling
__Heartburn
__Acid Regurgitation
__Ulcer
__Craving Sweet Foods

Kidney /Urinary Bladder
__Low Back Pain
__ Low Back Weakness
__Aching Bones
__Cold Limbs
__Frequent Urination
__Wake to urinate
__Incontinence
__ Blood in Urine
__Night Sweats
__Low Sexual Drive
__Low Pitch Ring in Ears

Liver / Gall Bladder
__Frequent Sighing
__ "Lump" in Throat
__Depression
__Easily Angered
__Irritability
__Dizziness/Vertigo
__Stress
__Muscle Twitching
__Muscle Cramping
__High Pitch Ringing in Ears
__Soft or Brittle Nails
__Tingling or Numbness
__Joint Stiffness
__Headaches / Migraines
__Visual Problems
__Red Eyes
__ Dry / Itchy Eyes
__Blurred Vision
__Craving Sour Foods

Intestines
__Constipation
__Diarrhea
__Mucus in Stool
__Blood in Stool
__Undigested Food in Stool
__Dry Hard Stool

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Social and Lifestyle

Water intake per day?_____ Caffeine intake per day_____

Tobacco:___Y___N How often?_____ Alcohol___Y____N How often?_____

Diet (please describe your typical daily diet)

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Non-Alcoholic Beverages: _____

For patient review, regarding diagnostic exam *Please sign one of the 2 options below*

Option 1

I have received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment.

X _____

Patient signature Date

Option 2

I have not received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment. Ohio law requires that a Licensed Acupuncturist recommend that you receive a diagnostic exam by a physician or chiropractor regarding the condition for which you are seeking treatment. X

_____

Patient signature Date

Payment Policy: All payments are due at the time of service. Appointments that are cancelled or missed with less than 24 hours advance notice may be charged a full session service fee.

*I have read and fully agree to financial policies: Signature*_____*Date*_____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including 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, 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 ownbenefit.

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 ArbitrationAgreement.

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 firstprofessionalservices.

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**

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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

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted.
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care.
- I have been offered a copy of this consent form.

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient	Parent / Guardian	Witness
Signature: _____	Signature _____	Signature _____
Name _____	Name _____	Name: _____
Date _____	Date _____	Date: _____