Stamps Chiropractic Wellness Center
Oriental Medicine Health Care

Patient Intake Form

Thank you for coming. Please take the time to fill out this questionnaire carefully, honestly, and completely. All of your information will be confidential. If you have any questions, please ask.

Personal Information

Name (First, Middle, Last): _____

Today's date: ___/___/___ Address (street): _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Cell Phone: _____ First preference for appointment reminders (circle): Home Cell

E-mail: _____ May practitioner contact you via E-mail (circle): Yes No

Date of Birth: ___/___/___ Age: _____ Gender (circle): M F Marital Status (circle): S M D W

Emergency Contact Name: _____ Contact's Phone: _____

Contact's Relation to you: _____ Who can we thank for referring you to our office? (If found online please list the website): _____

Please initial here to give your permission for us to thank the person who referred you for treatment: _____

Cancelation Policy

Out of respect for the practitioner's time and in order to maximize availability to patients, a minimum of 24 hours of notice for cancelations is required. Not providing 24 hours of notice, not showing, or being more than 15 minutes late for an appointment results in a charge of the standard fee to your account. If your appointment slot is filled after you cancel, this fee is waived. Compliance with this policy enables better service to you and other patients. Thank you for your understanding.

Patient's Signature: _____ Date: _____

Present illness/injury/or concern

Please describe the health problem(s) for which you are seeking treatment. Please include whether you have received a medical diagnosis.

_____

_____

When did this begin?

_____

What treatment(s) have you already received?

_____

Medical History

What medications are you currently taking? (Please include dosages and non-prescription medicines)

_____

_____

_____

_____

List all allergies you may have. (Please include food, medications, and nature allergies)

_____

_____

_____

Please list any hospitalizations and surgeries. (Please include date)

_____

_____

When was your last physical exam? Where any abnormalities found? (If so please explain)

_____

_____

Do you have any surgical implants, including pacemaker?

_____

Indicate any significant illness(es) you have or have had in the past:

☐ Cancer	☐ Bleeding Disorder	☐ Tuberculosis
☐ High Blood Pressure	☐ Blood Disorder/Anemia	☐ Breathing Problems
☐ Heart disease	☐ Hepatitis ____	☐ Rheumatic Fever
☐ Stroke	☐ HIV/AIDS	☐ Autoimmune Disorder
☐ Diabetes	☐ Venereal Disease	☐ Seizures
☐ Digestive Disorder	☐ Emotional Disorders	☐ Other: _____

Family History

Have any of your blood relatives had any of the following?

☐ Stroke	☐ Bleeding Disorder	☐ Thyroid Disorder
☐ Heart Disease	☐ Blood Disorder	☐ Kidney Disease
☐ High Blood Pressure	☐ Cancer	☐ Diabetes

General Health

Please indicate the use and frequency of the following:

☐ Tobacco _____ ☐ Coffee/Black tea _____ ☐ Alcohol _____

What types of exercise do you do during the week? How often and for what duration?

_____

How many hours per week do you work? What kind of physical exertion does your work require? (sitting-desk work, standing, labor, etc.)

_____

Please give a brief description of what you eat and drink on a typical day, including times of consumption.

_____

_____

On average, how many hours do you sleep each night? Any difficulty falling or staying asleep?

_____

Women:

Age of your first period: _____

Length of flow (days): _____

Length of menstrual cycle: _____

Number of pregnancies: _____

Number of live births: _____

Are you pregnant or is it possible: _____

Any abnormal vaginal discharge (Circle): Yes No

If yes, what color is it: _____

Date of last gynecological checkup: _____

Was everything normal? (If not, please explain)

_____

Date of last period: _____

Do you have a history of any of the following?

☐ Menstrual Cramps	☐ Vaginal Yeast Infections	☐ Infertility/Difficulty Getting Pregnant
☐ Excessive Bleeding	☐ Abnormal Pap Smear	☐ Difficulty Staying Pregnant
☐ Spotting	☐ Breast Swelling/Tenderness	☐ Breast Cysts
☐ Irregular Cycle	☐ History Of Hormone Therapy	☐ Endometriosis
☐ Menstrual Blood Clots	☐ Ovarian Cysts	☐ Hysterectomy
☐ Emotional Changes With Period	☐ Hot Flashes	☐ Other: _____
☐ PMS	☐ Vaginal Dryness	

Men:

Do you have a history of any of the following?

☐ Nocturnal Emissions	☐ Erectile Dysfunction	☐ Infertility
☐ Ejaculation Problems	☐ Prostate Problems	☐ Painful/Swollen Testicles

Check here if you do not want to discuss or treat the above conditions ☐

Symptom Survey

Please indicate if you have had *(in the last three months)* any of the following:

General

□ Poor appetite □ Poor sleep □ Fatigue □ Fevers □ Chills □ Night sweats Sweat easily □ Tremors □ Cravings
□ Change in appetite □ Poor balance □ Localized weakness □ Weight loss □ Weight gain □Peculiar tastes
□ Desire for hot food □ Desire for cold food □ Strong thirst (hot or cold drinks)
□ Sudden energy drop (What time of day) _____

Skin & Hair

□ Rashes □ Ulcerations □ Hives □ Itching □ Eczema □ Pimples □ Acne □ Dandruff □ Dry skin □ Recent moles
□ Obvious change in a mole or wart □ Purpura □ Change in hair of skin texture □ Warts □ Jaundice
□ Other _____

Musculoskeletal

□ Joint disorders □ Muscle weakness □ Pain/soreness in the muscles □ Fibromyalgia □ Tremors
□ Cold hands/feet □ Difficulty walking □ Swelling of hands/feet □ Spinal curvature □ Back pain □ Hernia
□ Numbness □ Tingling □ Paralysis □ Neck tightness □ Neck pain □ Shoulder pain □ Hand/wrist pain □ Hip pain
□ Knee pain □ Joint sprain □ Other _____

Head, eyes, ears, nose, and throat

□ Dizziness □ Concussions □ Migraines □ Glasses/lens □ Eye strain □ Eye pain □ Color blindness □ Poor vision
□ Cataracts □ Blurry vision □ Spots in front of eyes □ Earaches □ Ringing in ears □ Poor hearing
□ Sinus problems □ Nose bleeding □ Sore throat □ Grinding teeth □ Teeth problems □ Facial pain □ Jaw clicks
□ Sores on lips/tongue □ Difficulty swallowing □ Other _____

Cardiovascular

□ High blood pressure □ Low blood pressure □ Chest pain □ Palpitations □ Fainting □ Irregular heartbeat
□ Rapid heartbeat □ Phlebitis □ Varicose veins □ Other _____

Respiratory

□ Cough □ Coughing blood □ Production of phlegm (What color?) _____ □ Wheezing □ Difficulty breathing
□ Chest pain □ Asthma □ Emphysema □ Hoarseness □ Bronchitis □ Pneumonia □ Other _____

Gastrointestinal

□ Nausea □ Vomiting □ Diarrhea □ Constipation □ Chronic laxative use □ Change in bowl habits □ Gas
□ Irritable Bowel Syndrome □ Belching □ Indigestion □ Colitis □ Acid reflux □ Peptic ulcer □ Bad breath
□ Black stools □ Blood in stools □ Rectal pain □ Hemorrhoids □ Abdominal pain/cramps □ Parasites
□ Gallbladder problems □ Other _____
Bowel movements:
Frequency: _____ Color: _____ Foul Odor: Y/N Texture/form: Loose/Formed/Small Pieces/Dry

Neuro-psychological

□ Loss of balance □ Lack of coordination □ Concussion □ Depression □Anxiety □ Stress □ Bad temper □Bi-polar
□ ADHD/ADD □ Worry easily □ Tendency to become obsessive □ Other _____

Genito-urinary

□ Painful urination □ Frequent urination □ Blood in urine □ Abnormal discharge □ Urgency to urinate
□ Change in bladder habits □ Kidney stones □ Unable to hold urine □Dribbling □ Pause of flow □ STD's
□ Frequent urinary tract infection □ Genital pain □ Genital itching □ Genital rashes □ Low Sexual Drive
□ Excessive Sexual Drive □ Other _____

I have completed this form correctly to the best of my knowledge.

Signature: _____ ☐ Adult patient ☐ Parent or Guardian ☐ Spouse

Date: _____

Stamps Chiropractic Wellness Center

Notification Form Regarding Evaluation of Patient by Physician
(Pursuant to the requirement of section 183.7(e) of this title and section 6.11, Subsection (d) V.A.C.S. article 4495b, governing the practice of acupuncture)

I (patient's name), _____ am notifying the practitioner, Brianna del Castillo , L.Ac. of the following:

☐ Yes ☐ No I have been evaluated by a physician or dentist for the condition being treated within twelve (12) months before the acupuncture was performed. I recognize that a physician or dentist should evaluate me for the condition being treated by the acupuncturist.

_____ _____
(Patient Signature) (Date)

OR

☐ Yes ☐ No I have received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is _____, and the most recent date of chiropractic treatment prior to acupuncture treatment is _____. After being referred by a chiropractor, if after 60 days or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician.

It is my responsibility and choice to follow this advice.

_____ _____
(Patient Signature) (Date)

OR

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for one of the following conditions:

☐Chronic Pain

☐Weight Loss

☐Smoking Cessation

_____ _____
(Patient Signature) (Date)

OR

The acupuncturist has referred me to a physician. It is my responsibility and choice to follow her advice

_____ _____
(Patient Signature) (Date)

Stamps Chiropractic Wellness Center

Notice of Privacy Policies

Effective date: February 2005

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

This notice describes how we may utilize and/or disclose your health information to carry out treatment, payment, or health care operations and for other purposes that are permitted by law. This notice outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide to you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care.

How we may use or disclose your health information:

- **For treatment:** Only with your written approval, we may disclose your health information to your physician or another health care provider to be sure those parties have all the information necessary to diagnose and treat you.
- **For payment:** We may utilize and disclose **our** health information to others so we can receive payments for treatments rendered. For example, a bill may be sent to you or your insurance company. The bill may contain information that identifies you, your diagnosis, and treatment and supplies used in the course of treatment. We may disclose your information to a third party that performs services, such as bill collection, on our behalf. In these cases, we will enter into a written agreement with the third party to ensure they protect the privacy of your health information.
- **Appointment reminders:** We may use and disclose your health information in order to contact you and remind you of an upcoming appointment for treatment. We may also contact you by telephone to inquire about your well-being after receiving a treatment. In addition, we may send you newsletters or flyers throughout the year to provide you with the latest information on acupuncture and oriental medicine.

We are required by law to utilize and/or disclose your health information without your authorization for the following purposes:

- **As required by law:** We may use and disclose your health information when required to do so by federal, state, or local law, for example, to comply with a court order, warrant, subpoena, summons, or similar process.
- **Workers' Compensation:** We may disclose your health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.
- **Other uses and disclosures of your health information:** Other uses and disclosures or your health information not covered by this notice or the laws that apply to us will be made only with your written authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by the revoked authorization, except to the extent that we have taken action in reliance on your authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding health information we maintain about you:

- **Right to Request Restrictions:** You have the right to request restrictions on how we use and disclose your health information for treatment, payment, or health care operations. We are not required to agree to your request. If we do agree, we will comply with your request to the best of our ability. To request restrictions, you must make your request in writing.
- **Right to Request Confidential Communications:** You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or at home. To request confidential communications, you must make your request in writing. We will not ask the reason for your request. We will attempt to accommodate all reasonable request.
- **Right to Inspect and Copy:** You have the right to inspect and copy health information that may be used to make decisions about your care. Usually this includes medical and billing records. To inspect and copy your health information, you must make your request in writing by filling out the appropriate form provided by us. If you request a copy of your health information, we will charge a fee for the copying, mailing or preparing the requested documents.
- **Right to Amend:** If you feel that your health information is incorrect or incomplete, you may request that we amend your information. To request an amendment, you must submit your request in writing.
- **Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice at any time.
- **Right to Complain:** If you have any questions about this notice, or would like to file a complaint about our privacy practices, please direct your inquiries in writing. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against or penalized for filing a complaint.

Changes to This Notice
We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice.

This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____
Patient Name (Print)

_____ _____
Patient Signature Date signed

_____ _____
Name of Guardian (Print) Relationship or authority

_____ _____
Guardian Signature Date signed

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. 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 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.

BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY [illegible] DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT[illegible] CONTRACT.

PATIENT SIGNATURE X _____ (Date) _____

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

OFFICE SIGNATURE X _____ (Date) _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

AAC-FED

A2004

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:

PATIENT SIGNATURE X (Date)

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE