**Healing Acupuncture & Chinese Herbal Medicine LLC**
**4816 Six Forks Rd Suite 102**
**Raleigh, NC 27609**
**(919) 803-2424**

Date: _____/_____/_____
All of your answers and remarks are kept confidential. If there is anything you wish to bring to my attention which is not asked here, please write in the comments section. Thank you very much! (Please write legibly.)

Name: _____ Gender: M_____ F _____
Phone: (Home): _____ (Work): _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____

Age: _____ Date of Birth: _____/_____/_____ Place of Birth: _____
Height: _____ Weight: _____ Marital Status: _____
In Emergency: Notify: _____

How did you hear about this clinic? _____
Referred by: _____

Have you been treated by Acupuncture or Chinese Herbal Medicine before? Yes____ No___

**Main Health Issue** you would like me to help with:
_____
_____
How long have you had this condition? _____
What was the cause or reason for current condition, if you can think of any? _____
_____
To what extent does this problem interfere with your daily activities (work, sleep, intimacy?)
_____
Have you been given any medical diagnosis by any physician? If yes, please write: _____
_____
What kind of treatment have you tried for this problem? _____
_____
Did this treatment work? _____

**Past medical history** (How long) Cancer: _____ Diabetes: _____
Heart disease: _____ Hepatitis: _____
High blood pressure: _____ Rheumatic fever: _____
Thyroid disorder: _____ Seizures: _____
Other: _____ Herpes: _____

Surgeries or significant dental work (type of and date):
_____
Birth history (prolonged labor, forceps delivery, etc.):
_____
Allergies (drugs, chemicals, foods/result):_____

**Family medical history** (check): Diabetes Cancer High blood pressure
Heart disease Stroke Seizures Asthma Allergies
Other _____
Signifcant trauma (auto accident, falls, loss of family, etc. / date): _____
_____
Medicines taken within the last two months & for what condition:
_____
_____
_____
Health supplements/vitamins currently taking: _____
_____
Do you exercise regularly? Yes ____ No ____ If yes, what and how often a week:
_____
Have you ever been on a restricted diet? If yes, what and how long? _____
_____
Please describe your average diet:
Morning: _____
Afternoon: _____
Evening: _____
How many packs of cigarettes do you smoke a day? _____
How much alcohol do you consume per week? _____
How much coffee, tea, or soft drinks do you drink per day? _____

**Current medical practitioners:**
Name Phone Number
_____
_____
_____
_____

Please check or underline if you have had any of these in the last three to six months:

General:
- Poor appetite
- Gaining weight
- Losing weight
- Fevers
- Sweats easily
- Localized weakness
- Bleed or bruise easily
- Peculiar tastes or smells
- Strong thrist
- Thrist, no desire to drink
- Sudden energy drop What time of time?_____
- Tired/sluggish after eating
- Poor sleeping
- Chills
- Fatigue
- Night sweats
- Cravings for _____
- Recurrent sore throats
- Sores on lips or tongue

Cardiovascular:
- High blood pressure
- Irregular heartbeat
- Cold hands or feet
- Low blood pressure
- Dizziness
- Swelling of hands
- Heart palpitation
- Chest pain
- Fainting
- Swelling of feet/edema
- Difficulty in breathing
- Other heart or blood vessel problems: _____

Skin and hair:
- Rashes
- Itching
- Dandruff
- Change in hair or skin
- Ulcerations

- Eczema
- Loss of hair
- Hives
- Pimples
- Recent moles
- Other hair or skin problems: _____

Gastrointestinal:
- Appetite (normal, poor, excess)
- Change in appetite
- Bad breath
- Belching
- Acid reflux
- Indigestion
- Abdominal pain or cramps
- Vomiting or nausea
- Gas
- Bowel movement (1 x day, 2 x day, 3 x day)
- Blood in stool
- Black stool
- Rectal pain
- Diarrhea
- Constipation
- Chronic laxative use
- Hemorrhoids
- Other stomach or intestinal problems: _____

Genito-Urinary:
- Pain upon urination
- Urgency to urinate
- Decrease in flow
- Frequent urination
- Unable to hold urine
- Blood in urine
- Kidney stones
- Sores on genitals
- Libido (low, medium, high)
- Other genital or urinary system problems: _____

Do you wake up to urinate?
Yes _____ No _____ How Often? _____
Any particular color to your urine: _____

Head, eyes, nose and throat:

- Glasses/contacts
- Poor vision
- Cataracts
- Color blindness
- Night blindness
- Blurry vision
- Eye pain
- Spots in front of eyes
- Earaches
- Ringing in the ears
- Poor hearing
- Nose bleeding
- Facial pain
- Sinus problems
- Grinding teeth
- Teeth problems
- Jaw clicks
- Headaches: where, when and how often a week? _____
- Migraines: where, when and how often a week? _____
- Other head or neck problems _____

Gyneocological: (for women)

- Regular menstrual cycle Yes _____ No _____
- Number of children _____
- Number of pregnancies: _____
- Age of first menstration: _____
- Average number of days of flow: _____
- How many days between periods: _____
- Vaginal discharge Yes_____ No_____ If yes what color (clear, brown, red or _____)
- Pregnant Yes _____ No _____
- Age of menopause (if applicable): _____
- Bleeding between periods: Yes _____ No _____
- Irregular periods
- Pain periods
- Last pap _____
- Breast lumps

Do you practice birth control?

Yes _____ No _____

What type and for how long? _____

Please complete the following menstrual chart: (for women)

| Circle one of description | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
|---|---|---|---|---|---|---|---|
| Color (normal, bright, red, pale, brown rust, dark, purple, other) | | | | | | | |
| Amount of flow (normal, heavy, light) | | | | | | | |
| Pain/cramps (location, dull, sharp, other) | | | | | | | |
| Clots (large, small, black, purple, red, other) | | | | | | | |
| Other | | | | | | | |
| | | | | | | | |

Do you experience any of the following pre-menstrual syndromes? (for women)

- Nausea
- Vomiting
- Food cravings
- Depression
- Headaches/migraines
- Water retention
- Irritability/mood swing
- Anxiety
- Other emotions? _____
- Sharp pain, where? _____
- Dull pain, where? _____
- Breast swelling/breast tenderness
- Vaginal discharge
- Changes in body/psyche prior to menstration
- Vaginal sores

Men only:

- Swollen testes
- Feeling of coldness or numbness in external genitalia
- Testicular pain
- Low libido
- Premature ejaculation
- Other _____

Musculoskeletal:

- Neck pain
- Back pain
- Sciatica
- Hand/wrist pain
- Muscle pains
- Muscle weakness
- Shoulder pain
- Knee pain
- Foot/ankle pain
- Hip pain
- What is the nature of the pain (aches, burning, pins & needles, weakness, coldness, burning etc.)

Neuropsychological:

- Seizures
- Areas of numbness
- Concussion
- Bad temper
- Dizziness
- Lack of coordination
- Depression
- Easily susceptible to stress
- Poor balance
- Poor memory
- Tremors
- Other neurological psychological problems:_____

Respiratory:

- Asthma
- Cough
- Bronchitis
- Difficulty in breathing when lying down
- Production of phlegm: what color _____
- Coughing blood
- Pneumonia
- Pain with a deep breath
- Other lung problems: _____

Please note the degree of severity of your problem now:

No problem_____ Worst imaginable

Other comments:_____

## Arbitration Agreement and Informed Consent, Page 1 of 2 - Please Sign Both Sides

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 i12nstead are accepting the use of arbitration. Further parties will not have the right to participate as a member of any class claims 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 all 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, preceptorship 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 office where 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. The agreement is intended to create an open book account unless 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 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 statue 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 invalidly 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** | Date |
|---|---|
| (Or Patient Representative) | (Indicate relationship if signing for patient) |
| Office Signature **X** | Date |

Also Sign the Informed Consent on Reverse side

**NOTE: This is a copy for your records. At the clinic, you will sign the original form**

## 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 patients 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 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 candor scarring are a potential risk of moxibustion and cupping, 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 the 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, 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.

| Acupuncturist Name: | Doug C. Ko |
|---|---|

| Patient Signature **X** | Date |
|---|---|

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

Also sign the Arbitration Agreement on Reverse Side

**NOTE: This is a copy for your records. At the clinic, you will sign the original form.**

# Acknowledgement of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices for the office of Healing Acupuncture & Chinese Herbal Medicine LLC, detailing how my information may be used and disclosed as permitted under federal and state law.

**Signed:** _____ **Date:** _____

If not signed by patient, please indicate relationship to patient (e.g., mother) and patient's name.

**Patient:** _____

**Relationship:** _____

# Notice of Privacy Policies

Our office is dedicated of 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.

We gather personal information and health information in several ways;

- Information we receive from you.
- Information we receive from other healthcare provider.
- Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations.
You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations.
You may specifically authorize us to protect health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing
This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, newsletters, brochures, postcards and appointment reminder, by calls, postcards, letters, email or text.

Disclosure
This office may use or disclose your Protected Health Information when required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be writing.
5. You have a right to receive all notices in writing.

If you have questions, complaints or want more information contact this office.

Contact: Office manager or the main practitioner
Telephone: (919) 803-2424
Address: 4816 Six Forks Rd Suite 102, Raleigh, NC  27609
Send a written complaint to the U.S. Department of Health and Human Services.