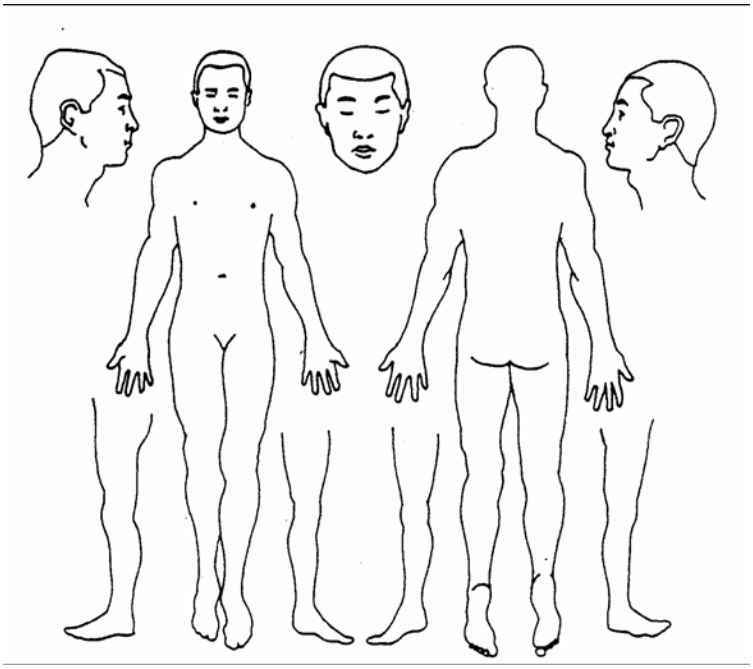
ACUPUNCTURE
HEALING & WELLNESS CENTER
Cheryl Stecki, L.Ac., MSTOM

NAME_____ **DATE**_____

I. Goals: What would you most like to achieve through your work at Acupuncture Healing and Wellness Center?
1. _____
2. _____
3. _____
4. _____
5. _____

II. Major Symptoms: Please list in order of importance what symptoms are of concern to you.
(most concerning to least, along with the duration of the symptom)
1. _____
2. _____
3. _____
4. _____

Use the following illustration to indicate painful or distressed areas:



Are you experiencing pain/discomfort in any area of your body? **Y / N**

If yes, using the models to the left, please indicate the location of the discomfort by using the symbol that best describes the feeling:

X X X Sharp/stabbing
P P P Pins & Needles
D D D Dull/Aching
N N N Numbness

For Women:
1. Are you pregnant now? [ ]Yes [ ]No [ ]Unsure

2. Indicate number of occurrences:
Live Births _____ Pregnancies_____ Miscarriages _____ Abortions _____

3. Age: First period _____ Menopause (if applicable) _____

4. Date: Last Pap Smear _____ /_____ Last Mammogram _____ / _____

5. Any History of an Abnormal Pap Smear? [ ] Yes [ ] No If so, what / when? _____

6. Is your menses cycle regular? [ ] Yes [ ] No
a) Average number of days of flow _____
b) The flow is: [ ] Normal [ ] Heavy [ ] Light
c) The color is: [ ] Normal [ ] Dark [ ] Purple [ ] Light Brown [ ] Brown

7. Do you have the following menstruation related signs/symptoms?

[ ] Difficulty with Orgasm	[ ] Cramps	[ ] PMS	[ ] Heavy Vaginal discharge between periods
[ ] Pain with Intercourse	[ ] Nausea	[ ] Bleeding between Periods	
[ ] Blood Clots	[ ] Breast Distention	[ ] Vaginal Discharge	

For Men:
1. Do you have any bothersome urinary symptoms? [ ] Yes [ ] No

Describe:_____

2. Check all that apply:

[ ] Erectile dysfunction	[ ] Difficulty with orgasm	[ ] Pain or swelling of the testicles	[ ] Frequent need to urinate at night
[ ] Impotence/erectile dysfunction	[ ] Premature ejaculation	[ ] Feeling of coldness or numbness in genitalia	
	[ ] Pain/Subtly of testicles		

3. Do you get up at night to urinate? [ ] Yes [ ] No How often? _____

4. To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)?
_____

5. Have you sought Medical intervention for these problems? If so, when? _____

_____

6. What treatments have you tried for these problems and how successful have they been?
_____

III. Medical History

Please check all that apply	***Date Diagnosed***		***Date Diagnosed***
Diabetes	___ / ___ / ___	High Cholesterol	___ / ___ / ___
High Blood Pressure	___ / ___ / ___	High Blood Pressure	___ / ___ / ___
Thyroid Disease	___ / ___ / ___	Seizures	___ / ___ / ___
Cancer	___ / ___ / ___	Hepatitis	___ / ___ / ___
HIV	___ / ___ / ___	Others	___ / ___ / ___

IV. Surgical History

_____ Date _____
_____ Date _____
_____ Date _____

V. Family History
Please check all that apply and state how you are related to the family member with that condition.

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Heart disease					
Cancer					
Hypertension					
Stroke					
Asthma					
Allergies					
Migraines					
Depression					
Other mental illness					
Substance abuse					
Osteoporosis					
Diabetes					
Glaucoma					

VI. Medications / Supplements
Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies (to medications, chemicals or foods):
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

VIII. Nutrition

1. Do you follow a special diet? [ ] Yes [ ] No If yes, how would you describe the diet?
(ie Vegetarian, Vegan, Low Carb, etc.)
_____
2. What do you eat on a "typical" day? _____
a) Breakfast _____
b) Lunch _____
c) Dinner _____
d) Snacks _____
e) Foods you tend to crave: _____
f) Foods you dislike: _____

IX. Social History

1. How much per day do you use of the following?

a) Coffee, tea, soft drinks: _____

b) Alcohol: _____

c) Cigarettes, cigars, other tobacco: _____

d) Other drugs: _____

2. Have you ever had a problem with *alcohol* or *alcoholism*? [ ] Yes [ ] No

3. Have you ever had a problem with *dependency* on other drugs? [ ] Yes [ ] No

4. If yes which and when?

_____

5. Do you have a known history of any exposure to *toxic* substances? [ ] Yes [ ] No

6. If so, please list which and when you first noticed symptoms?

_____

_____

7. In the past year, how many days have been significantly affected by your health? _____

8. How many days did you feel generally poor? _____

9. How many times were you in the hospital? _____

10. Please describe your current exercise regimen:

Hours per week: _____ Activities: _____ [ ] No Exercise

11. How many hours of sleep do you usually get per night during the week? _____

12. Do you awake feeling rested? [ ] Yes [ ] No Do you feel you sleep well at night? [ ] Yes [ ] No

13. Who would you describe as your source of primary social support? (relationship to you)

X. Other Information

Please list and briefly describe the most significant events in your life:

1. _____

2. _____

3. _____

4. _____

Have you been treated for emotional issues? [ ] Yes [ ] No

Have you ever considered or attempted suicide? [ ] Yes [ ] No

Do you have any other neurological or psychological problem? [ ] Yes [ ] No

Please provide us with any other information that you think is relevant for us to know:

_____

_____

_____

_____

_____

_____

HEALTH: CHECK ALL THAT APPLY

GENERAL

Past	Current	Condition
[ ]	[ ]	Poor appetite
[ ]	[ ]	Excessive appetite
[ ]	[ ]	Insomnia
[ ]	[ ]	Fatigue
[ ]	[ ]	Fevers
[ ]	[ ]	Night sweats
[ ]	[ ]	Sweat easily
[ ]	[ ]	Chills
[ ]	[ ]	Localized weakness
[ ]	[ ]	Poor coordination
[ ]	[ ]	Bleed or bruise easily
[ ]	[ ]	Catch cold easily
[ ]	[ ]	Change in appetite
[ ]	[ ]	Strong thirst
[ ]	[ ]	Other: _____

SKIN & HAIR

Past	Current	Condition
[ ]	[ ]	Rashes
[ ]	[ ]	Hives
[ ]	[ ]	Itching
[ ]	[ ]	Eczema
[ ]	[ ]	Pimples
[ ]	[ ]	Dryness
[ ]	[ ]	Tumors, lumps

HECK & NECK

Past	Current	Condition
[ ]	[ ]	Dizziness
[ ]	[ ]	Fainting
[ ]	[ ]	Neck stiffness
[ ]	[ ]	Enlarged lymph glands
[ ]	[ ]	Headaches
[ ]	[ ]	Concussions
[ ]	[ ]	Other: _____

EARS

Past	Current	Condition
[ ]	[ ]	Infection
[ ]	[ ]	Ringing
[ ]	[ ]	Decreased hearing
[ ]	[ ]	Other: _____

EYES

Past	Current	Condition
[ ]	[ ]	Blurred vision
[ ]	[ ]	Visual changes
[ ]	[ ]	Poor night vision
[ ]	[ ]	Spots
[ ]	[ ]	Cataracts
[ ]	[ ]	Glasses / contacts
[ ]	[ ]	Eye inflammation
[ ]	[ ]	Other: _____

NOSE, THROAT, MOUTH

Past	Current	Condition
[ ]	[ ]	Nose bleeds
[ ]	[ ]	Sinus infections
[ ]	[ ]	Hay fever or allergies
[ ]	[ ]	Recurring sore throats
[ ]	[ ]	Grinding teeth
[ ]	[ ]	Difficulty swallowing

CARDIOVASCULAR

Past	Current	Condition
[ ]	[ ]	High blood pressure
[ ]	[ ]	Low blood pressure
[ ]	[ ]	Blood clots
[ ]	[ ]	Palpitations
[ ]	[ ]	Phlebitis
[ ]	[ ]	Chest pain
[ ]	[ ]	Irregular heart beat
[ ]	[ ]	Cold hands / feet
[ ]	[ ]	Fainting
[ ]	[ ]	Difficult breathing
[ ]	[ ]	Swelling of hands / feet
[ ]	[ ]	Other: _____

RESPIRATORY

Past	Current	Condition
[ ]	[ ]	Asthma
[ ]	[ ]	Bronchitis
[ ]	[ ]	Frequent colds
[ ]	[ ]	Chronic obstructive
[ ]	[ ]	Pulmonary disease
[ ]	[ ]	Pneumonia
[ ]	[ ]	Cough
[ ]	[ ]	Coughing blood
[ ]	[ ]	Production of phlegm
[ ]	[ ]	Other: _____

GASTRO-INTESTINAL

Past	Current	Condition
[ ]	[ ]	Nausea
[ ]	[ ]	Vomiting
[ ]	[ ]	Diarrhea
[ ]	[ ]	Belching
[ ]	[ ]	Blood in stools/black
[ ]	[ ]	Stools
[ ]	[ ]	Bad breath
[ ]	[ ]	Rectal pain
[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Constipation
[ ]	[ ]	Pain or cramps
[ ]	[ ]	Indigestion
[ ]	[ ]	Gall bladder disorder
[ ]	[ ]	Gas
[ ]	[ ]	Other: _____

GENITO-URINARY

Past	Current	Condition
[ ]	[ ]	Kidney stones
[ ]	[ ]	Pain or urination
[ ]	[ ]	Frequent urination
[ ]	[ ]	Blood in urine
[ ]	[ ]	Urgency to urinate
[ ]	[ ]	Unable to hold urine
[ ]	[ ]	Other: _____

MALE

Past	Current	Condition
[ ]	[ ]	Pain / itching genitalia
[ ]	[ ]	Genital lesions/ discharge
[ ]	[ ]	Impotence
[ ]	[ ]	Weak urinary stream
[ ]	[ ]	Lumps in testicles
[ ]	[ ]	Other: _____

FEMALE

Past	Current	Condition
[ ]	[ ]	Frequent urinary tract infections
[ ]	[ ]	Frequent vaginal infections
[ ]	[ ]	Pain / itching of genitalia
[ ]	[ ]	Genital lesions / discharge
[ ]	[ ]	Pelvic inflammatory disease
[ ]	[ ]	Abnormal pap smear
[ ]	[ ]	Irregular menstrual periods
[ ]	[ ]	Painful menstrual periods
[ ]	[ ]	Premenstrual syndrome
[ ]	[ ]	Abnormal bleeding
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Breast lumps
[ ]	[ ]	Hot flashes
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Other: _____

NEUROLOGICAL

Past	Current	Condition
[ ]	[ ]	Seizures
[ ]	[ ]	Tremors
[ ]	[ ]	Numbness/tingling of limbs
[ ]	[ ]	Concussion
[ ]	[ ]	Pain
[ ]	[ ]	Paralysis
[ ]	[ ]	Other: _____

PSYCHOLOGICAL

Past	Current	Condition
[ ]	[ ]	Depression
[ ]	[ ]	Anxiety / stress
[ ]	[ ]	Irritability
[ ]	[ ]	Treated for emotional or
[ ]	[ ]	Psychological problems
[ ]	[ ]	Other: _____

INFECTION SCREENING

Past	Current	Condition
[ ]	[ ]	HIV
[ ]	[ ]	TB
[ ]	[ ]	Hepatitis
[ ]	[ ]	Gonorrhea
[ ]	[ ]	Chlamydia
[ ]	[ ]	Syphilis
[ ]	[ ]	Genital warts
[ ]	[ ]	Herpes: oral
[ ]	[ ]	Herpes: genital

MUSCULAR-SKELETAL

Past	Current	Condition
[ ]	[ ]	Stiff neck / shoulders
[ ]	[ ]	Low back pain
[ ]	[ ]	Back pain
[ ]	[ ]	Muscle spasm, twitching, cramps
[ ]	[ ]	Sore, cold or weak knees
[ ]	[ ]	Joint pain

ACUPUNCTURE
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PATIENT INFORMATION FORM

Please Note: This is a confidential record of your medical history. Information contained here will not be released to any person without your authorization.

First Name: M.I. Last Name:

Street Address: City:

State: Zip:

Home: ( ) Cell: ( ) Work: ( )

SS# Age: DOB:

Drivers License: Male: Female:

Employer: Occupation:

Married: ❑ Single: ❑ Divorced: ❑ Name of Spouse:

Emergency Contact: Phone:

Referred By:

PRIMARY INSURANCE Cash ❑ Group ❑ Work/Comp ❑ Auto ❑ Other ❑

Insurance Company: ID#: Group #:

Name of Insured: Relationship: Self ❑ Spouse ❑ Parent ❑

Secondary Ins: Name of Insured:

I understand this is a quotation of benefits and NOT a guarantee of payment. Agreement is between the insurance carrier and me. I authorize any and all payment from my insurance carrier directly to this office and understand that all monies be credit to my account upon receipt. Any denial of payment becomes my responsibility (patient).

Patient Name (Print) Signature Date

24 HOUR CANCELLATION POLICY AND AUTHORIZATION RELEASE

We take great pride in the quality of care for our patients. In order to facilitate this, we have a strict cancellation policy and require a 24 hour cancellation notice prior to your appointment time. If sufficient time is not given, the full fee will be charged.

I,_____ authorize Acupuncture Healing & Wellness Center to charge this credit card for; insurance copayments, services, cancellation fees and related charges.

- - - Exp. mo/yr: / Visa ❑ MC ❑

Patient Name (Print) Signature Date

30200 Rancho Viejo Road, Suite D ✖ San Juan Capistrano, CA 92675
(949) 293-9546

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 named 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 be 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.

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.

(Date)

PATIENT SIGNATURE **X**

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

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.

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 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 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, 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 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.

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