Janis Marion, L.Ac. | **AUSTIN LONGEVITY CENTER** | Phone: (512) 448-0900

NEW PATIENT HEALTH HISTORY

Thank you for your interest in acupuncture and Chinese herbal medicines. Please complete this health history.
All the information obtained in this history will help us assess you today and assist you in attaining your optimal health and wellness.

PATIENT INFORMATION

Today's Date:		
Last Name	**First Name:**	**Middle/ Initial:**
	Gender:	**Date of Birth:**
Street Address		
City:	**State:**	**ZIP Code:**
Home Phone: ( )	**Work Phone:** ( )	**Cell Phone:** ( )
Email Address:		
Spouse/Partners Name (if applicable):	Name(s) of Children (if applicable):	
How did you hear about us?		

EMERGENCY CONTACT

Emergency Contact:	**Emergency Contact Phone #:** ( )

EMPLOYMENT

I am currently: ☐ Working ☐ Student ☐ Retired Other _____

Job Title/Description: **Employer:**

INSURANCE PROVIDER INFORMATION

Who is responsible for this account?

Relationship to Patient:

Name of Health Insurance Provider:	**Type of Plan:**
MEMBER ID#:	**Group No.:**

PURPOSE OF APPOINTMENT

What is the primary concern for your visit today?

Other doctors you have seen for this condition:

Have you been treated for any other conditions in the past year? If so, please describe:

Medications you are currently taking:

Supplements you are currently taking:

Have you been treated with acupuncture before?

MEDICAL HISTORY

Check any conditions that you are currently experiencing or have had in the past:

- ☐ Alcoholism
- ☐ Auto Immune Disorder
  - ☐ Fibromyalgia
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy/ Seizures
- ☐ Liver Disease
  - ☐ Gallstones
  - ☐ Hepatitis
  - ☐ HIV / HPV
- ☐ Kidney Disease
  - ☐ Kidney stones

- Cardiovascular/ Circulatory/ Heart Disease
  - ☐ Hypertension
  - ☐ High Cholesterol
  - ☐ Chest pain or tightness
  - ☐ Palpitations
  - ☐ Rapid heart beat
  - ☐ Irregular heart beat
  - ☐ Low blood pressure
  - ☐ Anemia
  - ☐ Varicose veins
- ☐ Osteopenia/Osteoporosis
- ☐ Irritable Bowel Syndrome

- ☐ Measles/Mumps/ChickenPox
- ☐ Shingles
- ☐ Psychological Disorder
- ☐ STD
- ☐ Stroke
- ☐ Thyroid Disorder
  - ☐ Hypothyroid
  - ☐ Hyperthyroid/Hashimoto's
- Hair
  - ☐ Dry/ breaking
  - ☐ Thinning/ loss
  - ☐ Premature graying

Known allergies (airborne/ foods/ medications/ other):

Significant trauma (accidents or injury):

Hospitalizations and/or Surgeries:

FAMILY MEDICAL HISTORY (Please specifiy family member)

- ☐ Cancer _____
- ☐ Hepatitis _____
- ☐ Heart Disease _____
- ☐ Asthma _____
- ☐ Diabetes
- ☐ Stroke _____
- ☐ Hypertension _____
- ☐ Alcoholism _____
- ☐ Mental Illness _____
- ☐ Other

LIFESTYLE, DIET & EXERCISE

Describe your current exercise program:

Is your job active or sedentary? ☐ Active ☐ Sedentary

Is your work station 'ergonomic'?

Dietary restrictions?

Do you drink/use:

- ☐ Coffee
- ☐ Alcohol
- ☐ Tobacco
- ☐ Other 'recreational' drugs

How much/ how often: _____ _____ _____

PROFILE

OVERALL CONDITION/ BODY TEMPERATURE/ GENERAL MOOD & EMOTIONS

GENERAL ENERGY:

- ☐ Adequate/ good energy
- ☐ Low energy/ easily fatigued
- ☐ Feeling sluggish
- ☐ Exhausted
- ☐ Frequent illness/cold/flu/allergy

BODY TEMPERATURE:

- ☐ Hot
- ☐ Cold
- ☐ Cold hands
- ☐ Cold feet
- ☐ Chills
- ☐ Fevers
- ☐ Strong thirst
- ☐ Little/no thirst

BRAIN/MENTAL/HEAD:

- ☐ Forgetful/poor memory
- ☐ Poor focus/ difficulty concentrating
- ☐ Foggy/fuzzy thinking/head
- ☐ Dizziness
- ☐ Fainting

SWEATING:

- ☐ Profuse
- ☐ Palm
- ☐ Feet
- ☐ Afternoon fever/flush
- ☐ Night sweating
- ☐ Hot flashing
- ☐ Lack of sweating

EMOTIONS:

- ☐ Sad
- ☐ Cheerful
- ☐ Easily angered
- ☐ Easily stressed
- ☐ Irritable
- ☐ Indecisive
- ☐ Worried
- ☐ Afraid
- ☐ Anxious
- ☐ Depressed
- ☐ Mood swings

Are you... IN PAIN? MUSCULOSKELATAL PROBLEMS.... Please circle/note on chart below:

- ☐ Muscle pain
- ☐ Muscle cramps/ spasms
- ☐ Weakened/flaccid muscles
- ☐ Limited range of motion
- ☐ Bone pain
- ☐ Broken bones
- ☐ Sore/weak knees/ankles
- ☐ Difficulty walking
- ☐ Nerve pain
- ☐ Numbness/tingling

Quality of PAIN:

- ☐ Moving/ traveling
- ☐ Burning
- ☐ Aching or dull
- ☐ Relieved by heat
- ☐ Relieved by cold
- ☐ Worse with weather

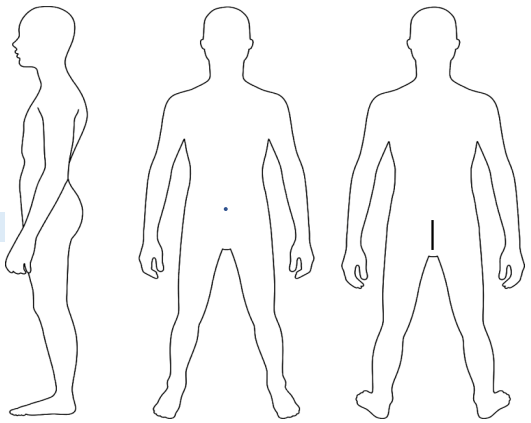
Syndromes of PAIN:

- ☐ Frozen shoulder
- ☐ Tendonitis
- ☐ Carpal tunnel
- ☐ Plantar fasciitis
- ☐ Headache
- ☐ Migraine
- ☐ Arthritis
- ☐ Rheumatoid Arthritis

SWELLING or EDEMA of:

- ☐ Hands
- ☐ Feet
- ☐ Ankles
- ☐ Legs
- ☐ Abdomen
- ☐ Bruise easily

Location of PAIN:



FEMALE SPECIFIC

First day of last menses: _____ **Number of days menses:** _____ **Number of days monthly cycle:** _____

Are you currently pregnant? _____ **Due date:** _____

Onset of menopause: _____ **Current signs/symptoms:** _____

ASSIGNMENT and RELEASE for INSURANCE CLAIMS / MISSED APPOINTMENT FEES

I have read and understand my acupuncture benefits as explained to me. I also understand that this is strictly an estimate and not a guarantee of payment according to my insurance company. I authorize payment of medical benefits to Austin Longevity Center and the release of medical records or other information necessary for the processing of my claims. I understand that this office will bill my insurance company as a courtesy to me, and if for any reason the insurance company does not pay or cover the services that I will be directly responsible for all charges. I authorize the use of this signature on all insurance submissions.

In addition, as regards missed appointments, I understand that any missed appointment without a prior 24 hour notice is subject to a fee of $35.

Patient Signature: _____ **Date:** _____

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

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. 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.

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