



**American Health Acupuncture LLC – Healing the Body Mind & Spirit
New Patient Oriental Medicine Intake Form**

Date _____

Name _____ DOB _____ Sex: M F

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Email _____

At which place(s) do I have permission to contact you? Cell / Home / Email

Emergency Contact _____ Relationship _____

Occupation _____ Height _____ Weight _____

Your Health Care Provider/MD? _____

In Emergency Notify _____ Relationship _____ Phone _____

Referred to us by (Dr., Friend, Internet, Other): _____

Have you been treated by Acupuncture or Oriental Medicine before? _____

1. What brought you here today? _____

2. When did you first notice any problems related to your chief complaint and what symptoms did you notice? _____

3. Describe what has happened from the first symptoms until today _____

4. What previous medical workups, diagnosis, and treatment have you had for this problem?

How have these been helpful or not? _____

5. Please list any allergies to drugs or medications: _____

6. What medications or supplements (prescription, over the counter drugs, vitamins, herbs, etc.) taken in the past 3 months?

<u>Medication</u>	<u>Dose</u>	<u>How long have you been taking it?</u>

7. Other Illnesses, Surgeries, Injuries, Infectious Diseases- Past or Present:

Year	Illness	Treatment/Medications	Outcome

Surgeries

Year	Illness	Treatment/Medications	Outcome

Injuries/Significant Trauma/Auto Accidents/Falls

Year	Illness	Treatment/Medications	Outcome

8. Do you have any implants or prosthetics? _____ If so, please describe: _____

9. Does your **Family Medical History** include any of the following:

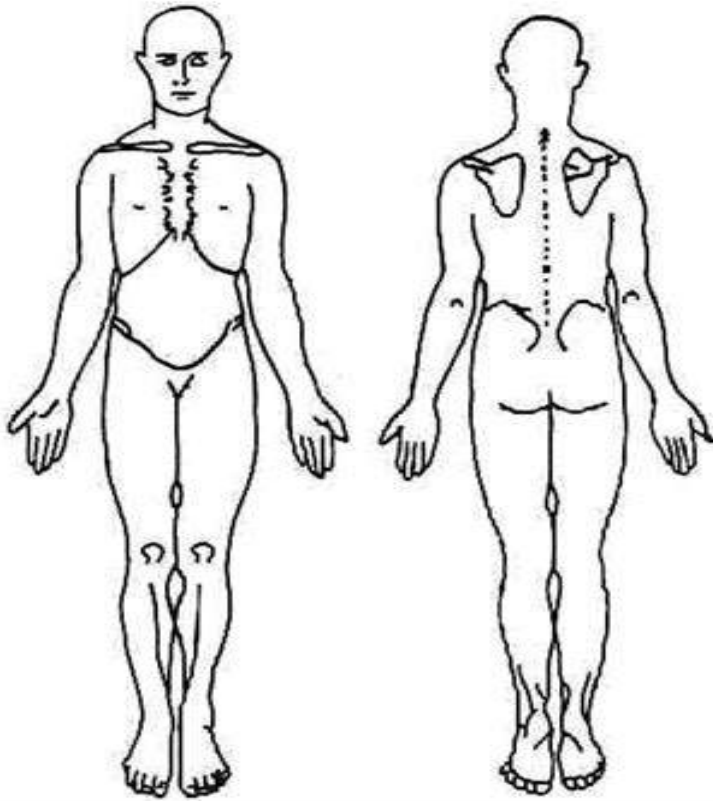
- Allergies
 Diabetes
 Emotional Difficulties
 Glaucoma
 Heart Problems
 Stroke
 Cancer
 Seizure Disorders
 Tuberculosis
 Thyroid Problems
 Hypertension/High BP

10. Please check any conditions or symptoms that you presently have or have had in the past:

	Presently Have	Had in Past		Presently Have	Had in Past
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Cough with blood	<input type="checkbox"/>	<input type="checkbox"/>	Sputum/Phlegm	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Lack of perspiration	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	Excessive perspiration	<input type="checkbox"/>	<input type="checkbox"/>
Chronic colds	<input type="checkbox"/>	<input type="checkbox"/>			

	Presently <u>Have</u>	Had in <u>Past</u>		Presently <u>Have</u>	Had in <u>Past</u>
Nasal or Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>	Nasal Polyps	<input type="checkbox"/>	<input type="checkbox"/>
Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>			
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Chest pains	<input type="checkbox"/>	<input type="checkbox"/>
Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	*High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	*Treatment _____		
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal cramping	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting with blood	<input type="checkbox"/>	<input type="checkbox"/>	*Laxative use	<input type="checkbox"/>	<input type="checkbox"/>
Gas	<input type="checkbox"/>	<input type="checkbox"/>	*Product _____		
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	Alternating diarrhea & constipation	<input type="checkbox"/>	<input type="checkbox"/>
Belching	<input type="checkbox"/>	<input type="checkbox"/>	Rectal pain	<input type="checkbox"/>	<input type="checkbox"/>
Acid regurgitation	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
Excessive appetite	<input type="checkbox"/>	<input type="checkbox"/>	Bowel movements every ____ days ____ total number of bowel movements a day		
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Burning on urination	<input type="checkbox"/>	<input type="checkbox"/>
Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>
Nighttime urination	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>
Unable to hold urine	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>
Bladder infections	<input type="checkbox"/>	<input type="checkbox"/>	Genital sores	<input type="checkbox"/>	<input type="checkbox"/>
Libido (sexual drive) is:	Normal <input type="checkbox"/>	Low <input type="checkbox"/>	High <input type="checkbox"/>		
Urine is:					
Normal Color	<input type="checkbox"/>	Cloudy	<input type="checkbox"/>	Difficult	<input type="checkbox"/>
Has Odor	<input type="checkbox"/>	Clear	<input type="checkbox"/>	Dark yellow	<input type="checkbox"/>
			<input type="checkbox"/>	Scanty	<input type="checkbox"/>
			<input type="checkbox"/>	Urgent	<input type="checkbox"/>
			<input type="checkbox"/>	Painful	<input type="checkbox"/>
			<input type="checkbox"/>	Burning	<input type="checkbox"/>
			<input type="checkbox"/>		
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	*Joint pain		<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	*Where _____		
Muscle spasms	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain		<input type="checkbox"/>
Back pain (lower)	<input type="checkbox"/>	<input type="checkbox"/>	Knee pain		<input type="checkbox"/>
Back pain (middle)	<input type="checkbox"/>	<input type="checkbox"/>	*Numbness		<input type="checkbox"/>
Back pain (upper)	<input type="checkbox"/>	<input type="checkbox"/>	*Where _____		
Pain down legs	<input type="checkbox"/>	<input type="checkbox"/>			

	Presently Have	Had in Past		Presently Have	Had in Past
Wear glasses	<input type="checkbox"/>	<input type="checkbox"/>	Eye tiredness / strain	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Seeing spots	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to light	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Eye dryness	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Eye redness	<input type="checkbox"/>	<input type="checkbox"/>
Eyes feel swollen	<input type="checkbox"/>	<input type="checkbox"/>	Eye itchiness	<input type="checkbox"/>	<input type="checkbox"/>
Pressure in the eye	<input type="checkbox"/>	<input type="checkbox"/>	Eye tearing	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>			
Hearing difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>	Ear infections	<input type="checkbox"/>	<input type="checkbox"/>
Ear pain	<input type="checkbox"/>	<input type="checkbox"/>			
Sore throats	<input type="checkbox"/>	<input type="checkbox"/>	Sore gums	<input type="checkbox"/>	<input type="checkbox"/>
Mouth dryness	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>
Bad taste in mouth	<input type="checkbox"/>	<input type="checkbox"/>	Sore tongue	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Numbness in tongue	<input type="checkbox"/>	<input type="checkbox"/>
Mouth sores/ulcerations	<input type="checkbox"/>	<input type="checkbox"/>	Grinding teeth	<input type="checkbox"/>	<input type="checkbox"/>
Changes in the skin color	<input type="checkbox"/>	<input type="checkbox"/>	Dandruff	<input type="checkbox"/>	<input type="checkbox"/>
Skin bruising	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Skin acne	<input type="checkbox"/>	<input type="checkbox"/>	Itchy skin	<input type="checkbox"/>	<input type="checkbox"/>
Body hair changes	<input type="checkbox"/>	<input type="checkbox"/>	Skin ulcerations	<input type="checkbox"/>	<input type="checkbox"/>
Sudden weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Sudden weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Problems with alcohol/drug use	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Psychological crisis	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	Psychoactive medications	<input type="checkbox"/>	<input type="checkbox"/>
Hot tempered	<input type="checkbox"/>	<input type="checkbox"/>	if yes, which ones? _____		
Stress	<input type="checkbox"/>	<input type="checkbox"/>	Emotional difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Stress Level 1 - 10: _____					
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Concussion	<input type="checkbox"/>	<input type="checkbox"/>
Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Headache / Migraine	<input type="checkbox"/>	<input type="checkbox"/>
Generally cold	<input type="checkbox"/>	<input type="checkbox"/>	Shaking / tremors	<input type="checkbox"/>	<input type="checkbox"/>
Cold hands and feet	<input type="checkbox"/>	<input type="checkbox"/>	Cysts / tumors	<input type="checkbox"/>	<input type="checkbox"/>
Heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Edema / water retention	<input type="checkbox"/>	<input type="checkbox"/>
Generally hot	<input type="checkbox"/>	<input type="checkbox"/>	Night sweating	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	if yes, difficulty falling asleep/staying asleep?		
Poor memory	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	<input type="checkbox"/>



Please circle on the diagram areas of pain or injury.

Please describe the type and quality of the pain:

Sharp Burning
 Aching Pressure-like
 Crampy
 Other _____

Do you smoke? _____ How much per day? _____

Do you drink Alcohol? _____ How much per week? _____

11. Nutrition

Please describe your average daily diet:

Morning: _____

Afternoon: _____

Evening: _____

Percentage of raw food _____ to cooked food _____

How much water do you drink per day? _____

How many caffeinated products (coffee, tea, carbonated pop) do you drink per day? _____

Do you get any food cravings? _____ If so, what? _____

When? _____ Preferred tastes: _____ Bitter Spicy Sour Salty Sweet

Snacks: _____

12. Exercise

What is your daily activity level related to your occupation?

- Sedentary (mostly sitting) Somewhat active Moderately active
 Very active (moving around or up most of the time) Heavy duty (lifting, moving things)

Menstruation:

Age of onset _____ Last Menstrual Period (first day) _____
Date of last Pap exam ____/____/____ Result _____
Length of usual period _____ days Length between periods _____

Regularity:

regular irregular usually early by ____ days usually late by ____ days varies between being early or late

Flow is: even uneven heavy light

Color is: pale pink light red red deep red purplish brown

Consistency is: thin thick clotted

Discomfort with Period

lower abdominal distention before during after menstruation
 lower back soreness before during after menstruation
 cramping before during after menstruation
 other _____

Premenstrual Syndrome (PMS)

irritability bloating mood swings breast tenderness
 other _____

Vaginal Discharge

No Yes If yes, color and amount: _____

Menopause

Age of onset _____ Any difficulties/symptoms? _____

Uterine bleeding (not related to periods)? No Yes Color _____ Amount _____
 comes on suddenly all the time

16. Patient Acknowledgement & Signature

***Copies of our policies are available to download online at our website www.AHAtucson.com or view a copy in our office reception area. Or we can print you a copy upon request.**

By signing your name in the space provided below, affirms you have read and received a copy of the American Health Acupuncture LLC's Notice of Privacy Practices, Payment, Cancellation, & Refund Policies and agree to its terms.

Signature of Patient:

Name: _____ Date: _____

Signature is required.

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, Juan R. Tejada, L.Ac. AZ.

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, nutritional and lifestyle 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 local bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting, mild pain or discomfort, a feeling of weakness, nausea, and a temporary aggravation of symptoms. These effects are unusual and of short duration. 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 this clinic uses sterile disposable needles, follows clean needle technique, and a 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, and I may stop treatment at any time.

I further understand that the evaluation given to me is an energetic assessment of the acupuncture meridian network, and in no way purports to be or replaces a western medical examination or diagnosis. In the course of the evaluation, there may be references to the state of various "organs", such as the heart, liver, spleen, kidneys, etc., which actually refers to the energetic system of the same name.

I acknowledge that Juan R. Tejada, L. Ac, is not and does not profess to be a western trained medical doctor and does not advise on the use of medically prescribed pharmaceuticals or medical treatment.

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 been read to me, the above consent to treatment and have had the opportunity to ask questions. This consent covers the entire course of treatments for my present condition and for any future condition(s) for which I seek treatment.

Patient _____ Date _____
(or patient representative)

(Indicate relationship if signing for patient) _____

Juan R. Tejada, L.Ac.
American Health Acupuncture LLC

7130 N Omar Dr. Tucson AZ 85741 Tel. 520-544-6603

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.

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 NAME (Print name): _____

PATIENT SIGNATURE: _____ DATE: _____
(Or Patient Representative)

(Indicate relationship if signing for patient) _____

OFFICE SIGNATURE: _____ DATE: _____