**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

Occupation_____Height_____Weight_____

Your Health Care Provider/MD? _____

In Emergency Notify _____ Relationship _____ Phone _____

☐ Married ☐ Single ☐ Divorced ☐ Other _____

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

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

_____

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

Medication Dose How long have you been taking it?

_____

_____

_____

8. **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 |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

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

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

10. **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: _____

11. **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)

In what kind of physical activities (exercise, sports) do you participate? Intensity level? How often per week? How long each time? _____

_____

_____

12. **More about you and your lifestyle:**

Hobbies and Recreational Habits _____

Travel abroad in the past year? _____ Where: _____

Current Emotional Health: _____ Current Quality of Life: _____

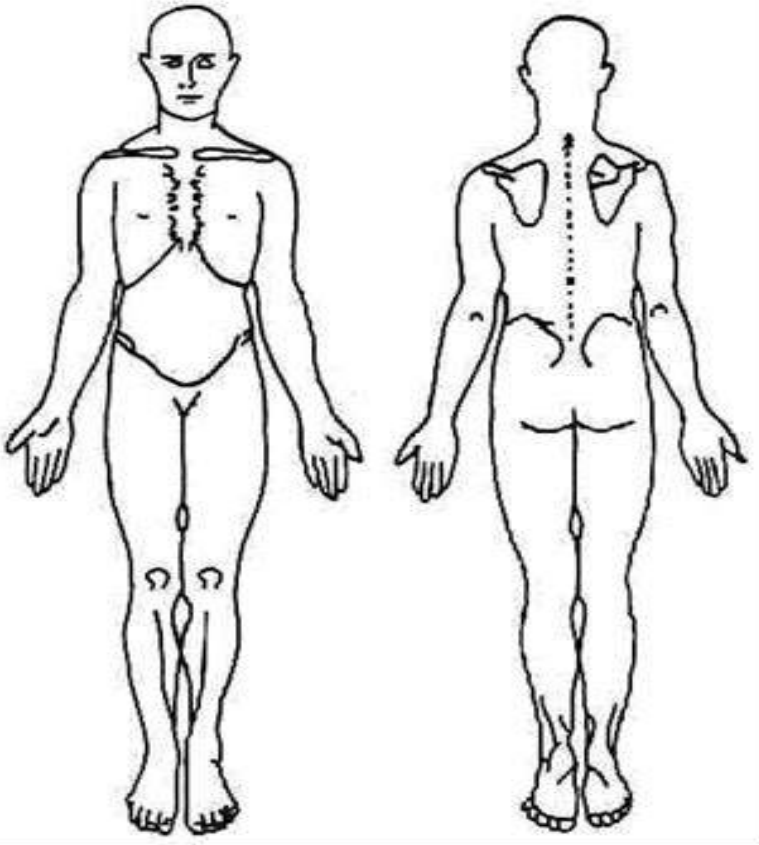
Current Relationship/Quality: _____ Current Predominant Emotion: _____

How are you today? (Scale of 1-10) Great OK Bad

10_____5_____1

How committed are you to getting well?

(10 is 100% Committed) 0_____5_____10



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_____

_____

_____

_____

_____

13**. Male Patients** – please fill out the following section then continue to #15:

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

| | Presently Have | Had in Past | | Presently Have | Had in Past |
|---|---|---|---|---|---|
| Prostate enlargement | ☐ | ☐ | Premature ejaculation | ☐ | ☐ |
| Prostatitis | ☐ | ☐ | Impotence | ☐ | ☐ |

---

14. **Female Patients** – please fill out the following section: Are you pregnant? Y N Not sure

Pregnancy: Please list history of pregnancy, note if full term (FT), premature (P), miscarriage (MC), and/or abortions (A). Whether vaginal (V) or Cesarean section (C). Note any difficulties you experienced during the pregnancy and/or after delivery (for example morning sickness, edema, prolonged bleeding after delivery, gestational diabetes, high blood pressure, fever postpartum, etc.)

Year

_____ _____
_____
_____ _____
_____
_____ _____
_____

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

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

| CURRENT | PAST | |
|---|---|---|
| | | Arthritis |
| | | Bell's Palsy |
| | | Concussion |
| | | Muscle spasms |
| | | High blood pressure* |
| | | *Treatment _____ |
| | | Stroke |
| | | Difficulty urinating |

| CURRENT | PAST | |
|---|---|---|
| | | Fibromyalgia |
| | | Cysts / Tumors |
| | | Low blood pressure |
| | | Insomnia* |
| | | * if yes, difficulty falling asleep? |
| | | Nightmares |
| | | Muscle weakness |
| | | Shaking / tremors |
| | | Grinding teeth |
| | | Sensitivity to light |

| CURRENT | PAST | |
|---|---|---|
| | | Bladder infections |
| | | Painful urination |
| | | Sore throats |
| | | Bleeding gums |
| | | Sore tongue |
| | | Vomiting with blood |
| | | Nose Bleeds |
| | | Eye itchiness |
| | | Eye pain |
| | | Ear pain |
| | | Facial Pain |
| | | Neck Pain |
| | | Knee pain |
| | | Rectal pain |
| | | Chest pains |
| | | Heart attack |
| | | Headache / Migraine |
| | | Seizures |
| | | Insomnia |
| | | if yes, difficulty staying asleep? |
| | | Irritability |
| | | Fevers |
| | | Problems with alcohol/drug use |
| | | Emotional difficulties |
| | | Psychological crisis |
| | | Psychoactive medications* |
| | | *if yes, which ones? _____ |

| CURRENT | PAST | |
|---|---|---|
| | | Eye redness |
| | | Eyes feel swollen |
| | | Ear infections |
| | | Sinus Infections |
| | | Mouth sores/ulcerations |
| | | Sore gums |
| | | Acid regurgitation |
| | | Poor appetite |
| | | Muscle pain |
| | | Back pain (lower) |
| | | Back pain (middle) |
| | | Back pain (upper) |
| | | Pain down legs |
| | | Joint pain* |
| | | *Where _____ |
| | | Dizziness |
| | | Hemorrhoids |
| | | Blood in stool |
| | | Burning on urination |
| | | Blood in urine |
| | | Genital sores |
| | | Sexually transmitted diseases |
| | | Anxiety |
| | | Depression |
| | | Hot tempered |
| | | Stress* |
| | | *Stress Level 1 - 10: ____ |
| | | Generally hot |
| | | Chills |
| | | Cold intolerance |

| CURRENT | PAST | |
|---|---|---|
| | | Anemia |
| | | Pressure in the eye |
| | | Eye tearing |
| | | Fainting spells |
| | | Numbness in tongue |
| | | Abdominal cramping |
| | | Vomiting |
| | | Diarrhea |
| | | Constipation |
| | | Laxative use* |
| | | *Product _____ |
| | | Alternating diarrhea & constipation |
| | | Bowel movements every _____ days |
| | | _____ total number of bowel movements a day |

| CURRENT | PAST | |
|---|---|---|
| | | Poor memory |
| | | Wear glasses |
| | | Blurred vision |
| | | Double vision |
| | | Cataracts |
| | | Glaucoma |
| | | Eye dryness |
| | | Eye tiredness / strain |
| | | Seeing spots |
| | | Hepatitis |
| | | Cholesterol |
| | | Cancer |
| | | Diabetes |
| | | Poor circulation |
| | | Varicose Veins |
| | | Edema / water retention |
| | | Lack of perspiration |
| | | Excessive perspiration |
| | | Parasites |
| | | Indigestion |
| | | Nausea |
| | | Ulcer |
| | | Gas |
| | | Bloating |
| | | Belching |
| | | Mouth dryness |
| | | Bad taste in mouth |
| | | Bad breath |
| | | Loss of taste |
| | | Numbness* |
| | | *Where _____ |

| CURRENT | PAST | |
|---|---|---|
| | | Heat intolerance |
| | | Sudden weight loss |
| | | Sudden weight gain |
| | | Nighttime urination |
| | | Kidney stones |
| | | Libido (sexual drive) is: Normal\|Low\|High |

| CURRENT | PAST | |
|---|---|---|
| | | Cold hands and feet |
| | | Generally cold |
| | | Night sweating |
| | | Frequent urination |
| | | Excessive urination |
| | | Unable to hold urine |
| | | Thyroid disorder |
| | | Hearing difficulties |
| | | Ringing in the ears |
| | | Loss of balance |
| | | Body hair changes |

Urine is:

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Normal Color | ☐ | Cloudy | ☐ | Difficult | ☐ | Scanty | ☐ | Urgent | ☐ | Painful |
| Has Odor | ☐ | Clear | ☐ | Dark yellow | ☐ | Reddish | ☐ | Burning | ☐ | |

| CURRENT | PAST | |
|---|---|---|
| | | Angina |
| | | Cough with blood |
| | | Pneumonia |
| | | Bronchitis |
| | | Seasonal allergies |
| | | Skin ulcerations |
| | | Sputum/Phlegm |
| | | Phlegm Color _____ |
| | | Nasal or Sinus |
| | | Palpitations |
| | | Skin rashes |
| | | Psoriasis |

| CURRENT | PAST | |
|---|---|---|
| | | Asthma |
| | | Chronic colds |
| | | Congestion |
| | | Cough |
| | | Shortness of breath |
| | | Tuberculosis |
| | | Nasal Polyps |
| | | Loss of smell |
| | | Fatigue |
| | | Irregular Heartbeat |
| | | Changes in the skin color |
| | | Skin bruising |
| | | Skin acne |
| | | Dandruff |
| | | Eczema |
| | | Itchy skin |
| | | Excessive appetite |
| | | Thirsty |

## 16. **Patient Acknowledgement & Signature**

***Copies of our Clinic 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.**

THANK YOU FOR NOT WEARING FRAGRANCE FOR MEDICAL REASONS - Office No Perfume Policy

Perfumes, aftershaves, hair-care products and other scented products affect the health of many people. The chemicals in fragrances give some people asthma, headaches, nausea or other symptoms.

Please do not wear perfume/aftershave or scented products when coming into this clinic.

Thank you for understanding.

By signing your name in the space provided below, affirms you have read the Office No Perfume Policy and 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: _____