Date _____

The Wellness Tree - Health History

Dr. Carrie J. Graves - Doctor of Oriental Medicine, Acupuncture Physician

Printed Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State:_____ Zip: _____

Phone: _____ Email:_____

Our office uses an online scheduling program that will alert you to future appointments via email. You can elect to not receive notifications with our office staff.

Gender: _____ Marital status: _____ Occupation _____

Emergency Contact Name _____ Contact Phone _____

Who may we thank for the referral?_____

Who is your primary care provider?_____

Have you had acupuncture before? Y / N Have you sought treatment for this condition before? Y / N

Chief Complaint

On a scale from 1-10 (10 being the worst) please rate your chief complaint(s) and how long it has been bothering you

Condition

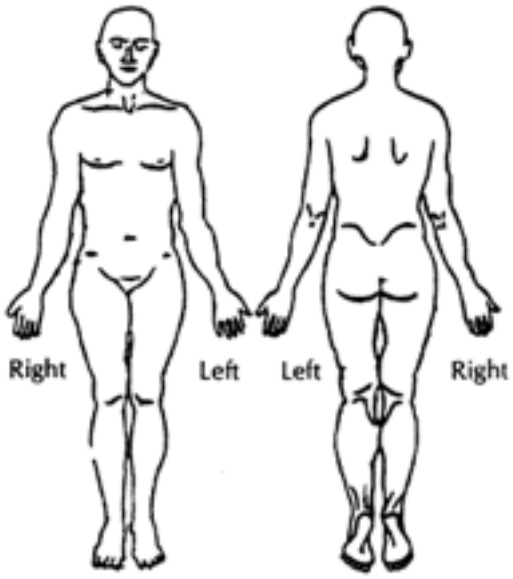
1 : _____

2: _____

3: _____

4 : _____

5 : _____



Please list all **prescription medications**, doses, conditions, and how long you have been taking the medication.

Medication	Dose (ex: 20mg, 2x daily)	Condition	Prescribed date (ex: August 2010)

Please list all **supplements and vitamins**, doses, conditions, brand, and how long you have been taking the medication

Medication	Brand	Dose (ex: 20mg, 2x daily)	Condition	Prescribed date (ex: August 2010)

With acupuncture and herbal therapies, dosages of medications may need to be adjusted **as my condition improves**. I understand that any changes in medication and/or doses will be done gradually and under the care of all my physicians. I will notify my prescribing practitioner of changes in dose or medication.

Signature_____ Date_____

General Health Information:

Please indicate if you or a family member has had or currently has any of the conditions below (parents, siblings, grandparents, children)

Allergies ○Self ○Family	Seizures ○Self ○Family	Kidney Disease ○Self ○Family
Arthritis ○Self ○Family	Heart Disease ○Self ○Family	Mental Illness ○Self ○Family
Bleeding disorder ○Self ○Family	Hepatitis ○Self ○Family	Stroke ○Self ○Family
Cancer ○Self ○Family	High Blood Pressure ○Self ○Family	Infectious Disease ○Self ○Family
Diabetes ○Self ○Family	HIV/AIDS ○Self ○Family	

Do you have a **PACEMAKER?**
○Yes ○No

Are you on **Blood Thinners?**
○Yes ○No

Are you **Pregnant** or trying to get pregnant?
○Yes ○No

Surgeries and Major Trauma (List type and date)

_____

_____

Allergies and Known Reactions

_____

_____

Lifestyle & Nutrition - check which substance you use and how often

○Alcohol _____
○Caffeine _____
○Marijuana _____
○Sugar_____
○Tobacco_____
○Soft Drinks _____
○Fast Food _____

Lifestyle & Nutrition - check which substance you use and how often

○Stress : None Low Med High
○Sleep Total Hours: _____
○Sleep Quality: Poor Good
○Hours per Week Working _____
○Hours per Week Commuting _____
○Hours per Day Sitting _____
○Hazardous Materials

_____

Diet - Please describe a typical day

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

INSTRUCTIONS: fill in only the circles which apply to you.

●○○MILD symptoms (occurs rarely)

○●○MODERATE symptoms (occurs several times a month)

○○●SEVERE symptoms (occurs almost constantly or daily)

Musculoskeletal

○○○ Joint Pain
○○○ Muscle Weakness
○○○ Pain
○○○ Cold hands/feet
○○○ Numbness/Tingling
Other: _____

_____

Head, eyes, ears, nose, & throat

○○○ Dizziness
○○○ Concussions
○○○ Headaches
○○○ Migraines
○○○ Eye Strain
○○○ Cataracts
○○○ Ringing in Ears
○○○ Night Blindness
○○○ Nose Bleeding
○○○ Sinus Pressure
○○○ Grinding Teeth
○○○ Mouth Sores
Other: _____

_____

Respiratory

○○○ Cough
○○○ Wheezing
○○○ Bronchitis
○○○ Pneumonia
○○○ Chest Pain
○○○ Phlegm in Chest
○○○ Asthma
Other: _____

_____

Cardiovascular

○○○ High Blood Pressure
○○○ Low Blood Pressure
○○○ Chest Pain
○○○ Palpitations
○○○ Dizziness when Standing
○○○ Irregular Heartbeat
○○○ Varicose Veins
○○○ Mitral Valve Prolapse
Other: _____

_____

Gastrointestinal

○○○ Nausea
○○○ Diarrhea
○○○ Constipation
○○○ Gas
○○○ Bloating
○○○ Acid Reflux
○○○ Bad Breath
○○○ Hemorrhoids
○○○ Gallbladder problems
○○○ Parasites
○○○ Abdominal Pain
Other: _____

_____

Genito-urinary

○○○ Painful Urination
○○○ Frequent Urination
○○○ Dribbling Urine
○○○ Night Urination
○○○ Kidney Stones
○○○ Genital Pain
○○○ Genital Itching
○○○ Frequent Infections
Other: _____

_____

Neuropsychological

○○○ Anxiety
○○○ Depression
○○○ Bad Temper
○○○ Irritability
○○○ Overthinking
Other: _____

_____

Skin

○○○ Rashes
○○○ Hives
○○○ Itching
○○○ Acne
○○○ Dandruff
○○○ Oily Skin
○○○ Dry Skin
Other: _____

_____

Men

○○○ Prostate Problems
○○○ Erectile Dysfunction
○○○ Fertility Problems
○○○ Painful/swollen testicles
Other: _____

_____

Women

○○○ Frequent Infections
○○○ Endometriosis
○○○ Hot Flashes
○○○ Ovarian Cysts
○○○ Irregular Periods
○○○ Moodiness
Age of first period _____

Date of Last Period _____
Duration of bleeding _____
Cycle Days _____
○○○ Cramps
○○○ Clot
Number of pregnancies _____
Number of births _____
Miscarriages _____
Abortions _____

PATIENT NAME:

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, 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, and 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 or preceptorship interns who now or in the future treat patient while employed by, working or associated with or serving as 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 the 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 the 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
(or Patient Representative) X

(Date)

(Indicate relationship if signing for patient)

PLEASE SIGN REVERSE SIDE ALSO

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 2 OF 2 – PLEASE SIGN BOTH SIDES

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/certified 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, bleeding, Gua-Sha, electrical stimulation, Tui-Na (Oriental massage), Oriental 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 or in writing. The herbs may have an unpleasant smell and/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. Bruising is a common side effect of cupping and Gua-Sha. 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 disposable sterile needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. 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 Oriental 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.

PATIENT SIGNATURE
(or Patient Representative) X (Date)

(Indicate relationship if signing for patient)

OFFICE SIGNATURE (Date)

OFFICE POLICIES

Welcome to our Practice! We have implemented certain office policies and procedures to ensure safety and the highest level of care.

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1. We do not dispense any herbal medicine or supplement to people who are not active patients within the last year.

2. We are available for communication primarily via phone and secondarily via e-mail. Please do not text, instant message, Facebook, Twitter, or otherwise attempt communication, as these may not be received and your medical confidentiality cannot be guaranteed. Likewise, if you e-mail and do not receive a return e-mail within 24 hours, please call the office; phone is the most reliable route of communication for our office.

3. Our physician is available for communication with active patients for quick questions that can be answered briefly. If you have a more complex question or lengthy explanation, or if your question requires an in-depth answer, we may ask that you schedule an appointment, either in-office or on-phone.

4. We try to return phone calls and e-mails within a few hours, but sometimes that is not possible. We do not have full-time receptionists and will make every attempt to return your phone call as soon as possible.

5. We do not practice emergency medicine. If you have an emergency, please call 911 or report to your local emergency room or urgent care clinic. If you have an urgent situation that you think does not require an emergency room visit, and you think our office may be able to help, please phone us. We will do what we can for you, but if your situation worsens or if you do not hear back from us within a time-frame that is appropriate for your situation, please call 911 or report to your local emergency room or urgent care.

6. We keep your health information private. If you would like a copy of our Privacy Practices, please let us know.

FINANCIAL POLICIES

Full Payment is due at time of service
Payment Methods Accepted: Cash, Check, Visa, Mastercard, Discover & American Express are accepted.

We do offer a $5 discount for cash and check

Returned Checks: Each returned check will incur a fee of $35.
Cancellations or Missed Appointments: We require a notice of 24 hours if you need to cancel an appointment, or you will be billed for a full treatment.

If you have a **Health Savings Account**: Acupuncture treatment is allowable under all HSA's. You will need to check with your specific HSA to find out if herbal medicine prescribed by a health professional is an allowable expense.

If your Health Insurance Policy Covers Acupuncture: We do not do insurance billing. At your request, we will provide you a superbill/receipt form which contains all the procedure & diagnostic codes prudent to your visit. You can submit a copy of this form to your insurance company for them to reimburse you directly.

If you are an Auto Injury Patient: Unfortunately, Florida PIP no longer covers acupuncture or massage therapy services. If You are a Medicare Patient: At this time, Medicare does not cover acupuncture services.

_____
I have read and agree to the above Office and Financial Policies

Signature_____ Date_____