

HEALTH QUESTIONNAIRE

Date ___/___/___

NAME _____ AGE _____ BIRTHDATE _____ SEX _____

ADDRESS _____ STREET _____ TOWN _____ ZIP CODE _____

HOME PHONE _____ OCCUPATION _____ WORKHOURS _____

WORK PHONE _____ EMPLOYER ADDRESS _____

REFERRED BY

Have you ever been examined by me before?

Yes

No

MARITALSTATUS

Single | Widowed

Married | Separated

Divorced

Presenting Problem

Current or recent M.D., D.O., or D.C., (Please circle one) Name and Diagnosis? Required by N.J. State

Do you have any pain? Please describe how it feels to you?

How is your energy?

How do you feel emotionally?

Describe your diet/eating habits:

How many servings of:

Fruit _____ / day or week

Vegetables _____ / day or week

Meat/Fish Fowl _____ / day or week

Soda _____ / day or week

Sugar/sweets _____ / day or week

Water _____ / day

Tea/CoffeeCups or Mugs _____ / day or week

Dairy (Milk, Cheese, Ice Cream): _____ / day or week

Flour Products: _____ / day or week

Whole Grains: _____ / day or week

List all allergies:

Do you smoke? How many a day? How many years?

Do you use alcoholic beverages? How often per day/week/month?

How many hours do you sleep nightly? Describe any difficulty.

Do you have a form of regular exercise? Describe.

List all current medications, **supplements**, eye drops, over the counter **preparations**, and **topicals**:

Anything significant about your birth?

Family History: (cancer, diabetes, high blood pressure, heart disease, stroke, **allergy, asthma, alcoholism, T.B., other**)

Mother:	Maternal Grandmother:	Children:
	Maternal Grandfather:	
Father:	Paternal Grandmother:	Siblings:
	Paternal Grandfather:	

Where do you hold tension?

What do you do for relaxation?

PAST MEDICAL HISTORY Measles (Vaccine) Mumps (Vaccine) Whooping Cough

Have you had: Chicken Pox (Vaccine) Scarlet Fever Diphtheria

Rheumatic Fever Diabetes **Mellitus** Poliomyelitis

HIV Tuberculosis Hepatitis A / B / C Lyme's Disease

CIRCLE ONE

Any other illness?

Describe **hospitalization** and surgery, dates:

Have you ever been treated for:

Mental **Illness**? _____ **Fracture**? _____ Head **Injury**? _____

Where? _____

REVIEW OF SYSTEMS

DIRECTIONS: If you can answer YES to the question asked put a circle around the YES. IF you can answer NO to the question asked, put a circle around the NO.

EYES, EARS, NOSE THROAT

Are you hard of hearing?	YES / NO
Do you have constant noises in your ears?	YES / NO
Have you at times had bad nose bleeds?	YES / NO
Do you suffer from a constantly runny nose?	YES / NO
Do your eyes continually blink or water ?	YES / NO
Do you often see spots before your eyes?	YES / NO
Is your vision poor?	YES / NO
Do you often have pain in your eyes?	YES / NO
Do you suffer from frequent sore throats?	YES / NO
Do you suffer from frequent ear aches?	YES / NO

RESPIRATORY

Do you frequently suffer from heavy chest cold?	YES / NO
Do you suffer from asthma?	YES / NO
Are you troubled by constant coughing?	YES / NO
Have you ever coughed up blood?	YES / NO
Have you ever had a chronic chest condition?	YES / NO
Do you often have pain in your chest when taking deep breaths?	YES / NO

CARDIOVASCULAR

Have you ever been told you had heart trouble?	YES / NO
Do you have pains in heart or chest?	YES / NO
Does exercise or excitement cause you to have pains in the chest?	YES / NO
Are you often bothered by thumping of the heart?	YES / NO
Has a doctor ever said your blood pressure was too low?	YES / NO
Has a doctor ever said your blood pressure was too high?	YES / NO
Do you often have difficulty breathing?	YES / NO
Do you often have to stop for breath when walking up stairs? How many flights? _____	YES / NO
Have you ever had to sit up to catch your breath?	YES / NO
Are your ankles often badly swollen?	YES / NO
Has a doctor ever said you had varicose veins?	YES / NO

GASTROINTESTINAL

Have you had an unexplained loss of weight?	YES / NO
Is your appetite always poor?	YES / NO
Do you usually belch a lot?	YES / NO
Do you usually pass a lot of gas by rectum?	YES / NO
Do you suffer from indigestion?	YES / NO
Do you suffer from frequent loose bowel movements (diarrhea)?	YES / NO
Are you constantly constipated?	YES / NO
How may bowel movements daily or weekly ? _____	
Do you frequently have severe stomach pains?	YES / NO
Do you have frequent vomiting?	YES / NO
Have you ever vomited blood?	YES / NO
Have you ever passed blood with your bowel movement?	YES / NO

GENITOURINARY

Do you have trouble holding your urine?	YES / NO
Have you ever dribbled urine when sneezing?	YES / NO
Have you ever had blood or gravel in your urine?	YES / NO
Do you often have pain or burning on urination?	YES / NO
Have you ever had a kidney disease?	YES / NO
Do you have trouble starting your stream when you urinate?	YES / NO
How is your energy sexually ? _____	
Are sexual relations painful or difficult for you?	YES / NO
Have you had a recent loss of interest in sexual relations?	YES / NO
What form of birth control do you use ? _____	

SKIN AND EXTREMITIES

Have you had arthritis or rheumatism? YES / NO
Are your joints often painfully **swollen**? YES / NO
Do you frequently get severe leg cramps when walking? YES / NO
Do you have any skin rashes? YES / NO
Describe any scars and how **acquired** _____

NEUROMUSCULAR

Do you suffer from frequent severe headaches? YES / NO
Are you usually nervous? YES / NO
Do you often have spells of severe dizziness? YES / NO
Do you frequently feel faint? YES / NO
Have you had a loss of strength or feeling in any part of your body? YES / NO
Was any part of your body ever paralyzed? YES / NO
Did you ever have a fit or convulsion (**epilepsy**)? YES / NO

HEMATOLOGY

Do you bruise more easily than normal? (Estimate) YES / NO
When you cut yourself do you bleed excessively? YES / NO
Do you have a history of anemia (low blood **count**)? YES / NO

ENDOCRINE

Do you have a history of having had thyroid trouble? YES / NO
Were you ever given thyroid tablets to take? YES / NO
Do you have any lumps or bumps anywhere in your body? YES / NO

OBSTETRICS & GYNECOLOGY

How old were you when you started **menstruating**? _____
Are your periods usually regular? YES / NO
When did your last period **begin**? _____
Usual # of days of **flow** _____ Usual# of days of **cycle** _____
Amount of **flow** _____ **Color** _____ **Clotting?** _____
Please describe any discomfort before **flow** _____
during **period** _____
Have you ever had vaginal bleeding between your menstrual periods? YES / NO
How many pregnancies have you **had**? _____
How many children have you **had**? _____
Have you had a miscarriage? How **many**? _____ YES / NO
Do you have vaginal burning or itching? YES / NO
Have you ever had a bloody nipple discharge? YES / NO

OFFICE POLICY- Please Read and Sign As Applies to You

I understand that Payment is due at the time of treatment

Signature

Date

**PATIENT AUTHORIZATION FOR PAYMENT OF MEDICDAL BENEFITS
AND RELEASE OF MEDICAL INFORMATION**

I authorize payment of medical benefits to AcuCare for acupuncture services rendered to me. Furthermore, I authorize the release of any medical information necessary to process my insurance claims to the insurance company or agency.

I understand that I am responsible for all charges not covered by this assignment.

Patient's name/Print

Patients/Guardian signature

Date



IV Statement of Acupuncture Procedures and Financial Policy

I, _____ hereby authorize Stewart M. Kaufman, LAC to treat me by way of acupuncture procedures, including but not limited to acupuncture, moxibustion, electro-stimulation, and cupping. I understand acupuncture does not act as a primary healthcare and the nature, consequences, and benefits of these procedures have been explained to me sufficiently, completely and in detail and are reiterated below:

1. Acupuncture is a system of therapeutic treatment that works on the body's energy pathways to resolve energetic imbalances. Acupuncture procedures involve the insertion of very **fine**, sterile needles into the surface of the body but also include moxibustion, cupping, electro-stimulation, manual pressure and other like techniques unique to the Practice of Oriental Medicine.
2. Potential risks may include discomfort at the site of insertion of the needle, irritation, pain and discomfort, bruising, weakness, fainting, nausea and possible temporary aggravation of symptom. These risks are rare and can be minimized by having proper nutrition and rest prior to the treatment and by communicating closely with the acupuncturist with regard to any uncertainty on the part of the patient.
3. Potential benefits are enhanced by avoiding bathing and showering for several hours after treatment, resting appropriately and following such general recommendations as the acupuncturist may make. Acupuncture may allow for painless and **drugless** relief of my presenting symptoms and improved balance of bodily energies that may lead to prevention or elimination of the presenting problem as well as other health balancing effects.
4. I understand that any disease requires diagnosis by a licensed M.D., physician and any change in pharmaceutical drug use should be medically monitored. Oriental medicine and acupuncture are not offered as primary care in the State of NJ/PA, rather they are **adjunctive** therapies for complementary health care.
5. Our financial policy is that you **SUBMIT PAYMENT** to our receptionist at the end of your treatment. You may pay either by cash or check. A receipt will be provided to you for tax purposes. You **MUST** give 24 hours notice of change of appointment or else you **MAY BE CHARGED FOR THE TIME YOU RESERVED!!** Late arrivals will be seen but you will not receive full treatment and are liable for the full fee.

Signature of **Patient/Guardian**

Date

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: AH 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 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 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.

PATIENT SIGNATURE
(Or Patient Representative)



(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 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 (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 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. 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. 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 effect 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
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PLEASE SIGN REVERSE SIDE ALSO