nature works
ACUPUNCTURE & CHINESE MEDICINE

HEALTH HISTORY QUESTIONNAIRE

TODAY'S DATE: _____

Primary Phone # (home/work/cell) Alternate Phone # (home/work/cell)

Email:_____

Would you like to join our e-mail list to receive our newsletter with clinic updates and special offers? ____YES ____NO

(Our newsletter is a good way to stay informed and special discounts and promotions. We send it infrequently, and we will not share your information with any third parties. You can unsubscribe easily at any time.)

First Name Last Name Nickname

Street Address Birth Date Age Gender

City, State, Zip Code Height Weight

Email Address Occupation

Emergency Contact Relationship to Client Emergency Contact Phone #

Primary Physician Physician's Phone #

Referred By How did you find out about us?

nature works
ACUPUNCTURE & CHINESE MEDICINE

How did you hear about us?

☆Print Ad ☆Web ☆Friend ☆Other _____

Have you been treated by acupuncture or oriental medicine before? ☐ **YES** ☐ **NO**

Have you had massage therapy or chiropractic treatment before? ☐ **YES** ☐ **NO**

Main problem(s) you would like to be treated for:
How long ago did this problem begin (please be specific)?
To what extent does this problem interfere with your daily activities?
Have you been given a diagnosis for this problem? If so, describe:
What kinds of treatment have you tried?

Please note the severity of your problem now (circle one):

1 2 3 4 5 6 7 8 9 10

No Problem Worst Imaginable

Please note the severity of your problem within the last week (circle one):

1 2 3 4 5 6 7 8 9 10

No Problem Worst Imaginable

Comments (please mention any other problems you would like to discuss):

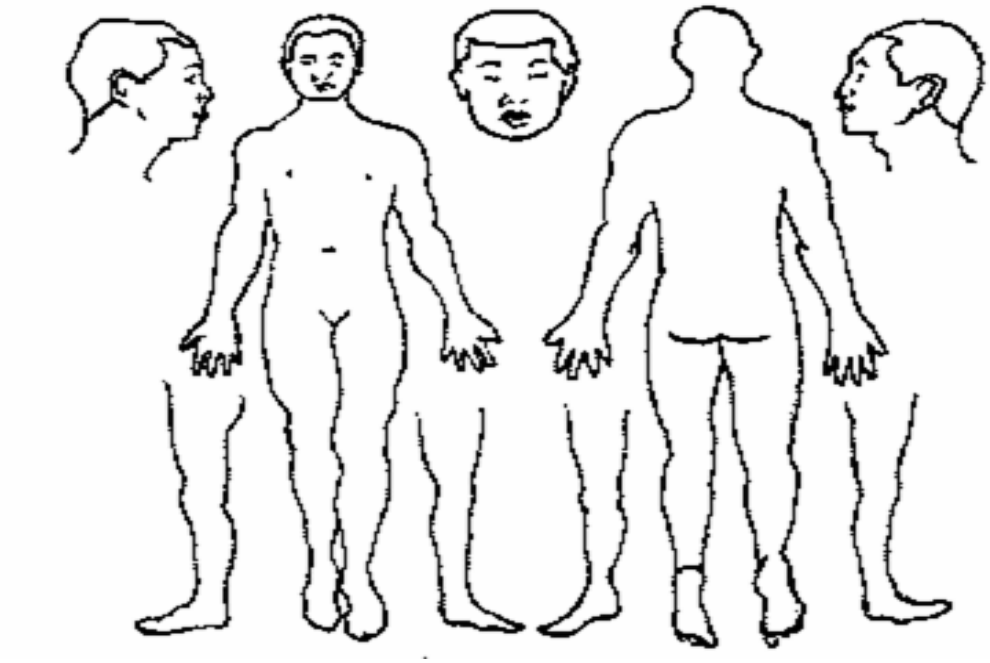
_____

_____

_____

_____

Indicate painful or distressed areas:



nature works
ACUPUNCTURE & CHINESE MEDICINE

Medications: (Please include any taken within the last two months, including vitamins, herbs, etc.)

PAST MEDICAL HISTORY (please include dates)

☐ Cancer		☐ Rheumatic Fever	
☐ Diabetes		☐ Thyroid Disease	
☐ Hepatitis		☐ Seizures	
☐ High Blood Pressure		☐ STDs	

☐ Other	
☐ Surgeries (type & date)	
☐ Significant Trauma (auto accidents, falls, etc.)	
☐ Significant Dental Work	
☐ Birth History	(Prolonged labor, c-section, etc.)
☐ Allergies	

nature works
ACUPUNCTURE & CHINESE MEDICINE

FAMILY MEDICAL HISTORY

☐ Cancer		☐ Heart Disease	
☐ Diabetes		☐ Thyroid Disease	
☐ Asthma		☐ Seizures	
☐ High Blood Pressure		☐ Stroke	

☐Occupational Stress	
☐ Regular exercise program	
☐ Restricted diet	
☐ Smoke	Number of cigarettes per day:
☐Coffee/tea/soda	Number of servings per week:
☐Alcohol	Number of servings per week:
☐ Non-medicinal drug use	

PLEASE CHECK ANY SYMPTOMS YOU HAVE HAD IN THE PAST THREE MONTHS

CARDIOVASCULAR	GENITO-URINARY	NEUROPSYCHOLOGICAL
☐ High blood pressure ☐ Irregular heartbeat ☐ Cold hands or feet ☐ Blood clots ☐ Low blood pressure ☐ Dizziness ☐ Swelling of hands or feet ☐ Phlebitis ☐ Chest pain ☐ Fainting ☐ Difficulty in breathing ☐ Other heart or blood vessel problems	☐ Pain during urination ☐ Urgency to urinate ☐ Decrease in flow ☐ Frequent urination ☐ Unable to hold urine ☐ Blood in urine ☐ Kidney stones ☐ Impotency ☐ Genital sores ☐ Other genital or urinary problems: _____ ☐ Do you wake up to urinate? If so, how often? _____	☐ Seizures ☐ Areas of numbness ☐ Concussion ☐ Bad temper ☐ Dizziness ☐ Lack of coordination ☐ Depression ☐ Easily susceptible to stress ☐ Loss of balance ☐ Poor memory ☐ Anxiety ☐ Other neurological or psychological problems

nature works
ACUPUNCTURE & CHINESE MEDICINE

RESPIRATORY

☐ Cough
☐ Bronchitis
☐ Difficulty in breathing when lying down
☐ Production of phlegm
What color? _____
☐ Coughing blood
☐ Pneumonia
☐ Asthma
☐ Pain while breathing deeply
☐ Other lung problems:
_____

GASTROINTESTINAL

☐ Nausea
☐ Constipation
☐ Black stools
☐ Bad breath
☐ Abdominal pain or cramps
☐ Chronic laxative use
☐ Vomiting
☐ Gas
☐ Blood in stools
☐ Rectal pain
☐ Diarrhea
☐ Belching
☐ Indigestion
☐ Hemorrhoids
☐ Other stomach or intestinal problems: _____

☐ Any particular color to your urine:
_____

PREGNANCY & GYNECOLOGY

☐ Number of pregnancies _____

☐ Number of births _____
☐ Premature births _____
☐ Miscarriages _____
☐ Abortions _____
☐ Age at first menses _____
☐ # days between periods _____
☐ Duration _____
☐ First date of last period _____
☐ Unusual character
_____
☐ Painful periods
☐ Vaginal discharge
☐ PMS
☐ Clots
☐ Vaginal sores
☐ Irregular periods
☐ Last Pap _____
☐ Breast lumps
☐ Birth control: _____

MUSCULOSKELETAL

☐ Neck pain
☐ Back pain
☐ Hand/wrist pain
☐ Muscle pain
☐ Muscle weakness
☐ Shoulder pain
☐ Knee pain
☐ Foot/ankle pain
☐ Hip pain

_____

GENERAL

☐ Poor appetite
☐ Fever
☐ Sweat easily
☐ Localized weakness
☐ Bleed or bruise easily
☐ Peculiar taste or smells
☐ Strong thirst (cold or hot)
☐ Low thirst
☐ Sudden energy drop
What time of day?_____
☐ Poor sleeping
☐ Chills or tremors

SKIN AND HAIR

☐ Rashes
☐ Itching
☐ Dandruff
☐ Change in hair or skin
☐ Ulcerations
☐ Eczema
☐ Hair loss
☐ Hives
☐ Acne
☐ Recent moles
☐ Other hair or skin problems

HEAD, EYES, EARS, NOSE,THROAT

☐ Grinding teeth
☐ Dental problems
☐ Concussion
☐ Eye strain
☐ Night blindness
☐ Blurry vision
☐ Poor hearing
☐ Nose bleeds
☐ Facial pain
☐ Jaw clicks
☐ Migraines
☐ Eye pain

☐ Poor balance ☐ Fatigue ☐ Night sweats ☐ Cravings ☐ Weight gain/loss	**HEAD, EYES, EARS,NOSE, THROAT** ☐ Dizziness ☐ Glasses ☐ Poor vision ☐ Cataracts ☐ Ringing in ears ☐ Sinus problems	☐ Color blindness ☐ Earaches ☐ Spots in eyes ☐ Recurrent sore throat ☐ Lip or tongue sores ☐ Headaches ☐ Other head or neck problems

Describe your average daily diet.

Morning	
Afternoon	
Evening	

nature works
ACUPUNCTURE & CHINESE MEDICINE

CLINIC & FINANCIAL POLICIES

The following financial policy has been established to support the administration of the clinic and its mission.

Fees are due at the time of treatment. Current fees are available online at NATUREWORKSACUPUNCTURE.COM. They are also posted at the clinic front desk.

Herbs vary in price and are not included in clinic treatment fees.

Our goal is to make acupuncture available to those who might not be able to afford it otherwise. Please inquire about discounts. NatureWorks Acupuncture accepts major insurances. However insurance coverage varies and eligibility has to be determined. Ultimately the financial responsibility lies by the patient. NatureWorks Acupuncture can provide a "SUPER-BILL", which the patient submits to his insurance provider. This bill contains all necessary information and insurance codes for REIMBURSEMENT of the treatment costs excluding herbs and other merchandise. Reimbursement depends on the individual patient policy. We ask for payment in full at the time of service. Payments can be made by credit card, cash or check; We accept VISA and MC only. We will make an effort to respond to requests for records for insurance claims in a timely manner.

We currently do offer a limited reduced fee for those who are low-income, or are on Disability or Medicaid. Please ask at the front desk about these reduced fees.

Natureworks Acupuncture prohibits the possession and use of all weapons, including but not limited to: firearms, knives, and mace, as well as noxious chemicals, fireworks and explosives.

We have limited clinic hours and there is often a waiting list. Therefore, we require 24 hours notice for changes or cancellations. **Appointments cancelled with less than 24 hours notice and appointments missed with no notification will be charged in full for that appointment.** Patients who qualify for a reduced fee will also be charged in full at the regular fee – not the reduced fee. Please pay for the missed visit at or before the next appointment. If you cancel two appointments with minimal or no notice, you will not be rescheduled until you have paid the cancellation fee for both visits. If there is a continued pattern of missed appointments, we may choose not to schedule you for appointments in the future. If necessary please change your appointment online at Natureworksacupuncture.com or by phone.

By signing this form, I am indicating that I understand and accept this policy.

Signature_____ Date _____

nature works
ACUPUNCTURE & CHINESE MEDICINE

TRADITIONONAL CHINESE MEDICINE INFORMED CONSENT TO TREAT

Licensed in Washington State as Hans-Thomas Richter EAMP, WA License # ACUP.AC.60412812

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. ***Patients with severe bleeding disorders, pace makers, diabetes, contagious diseases, cancer or lymphedema must inform practitioners prior to any treatment. Patients with a serious illness such as cancer are required to sign a "serious illness waiver".*** I understand that the acupuncturist is not providing Western (allopathic) medical care, and that I should look to my Western primary care practitioner (*i.e.* MD) for those services and for routine check-ups. I understand that the acupuncturist may review my patient records and lab reports.

I agree to the release of any medical information my health insurance may need in order to process payment. I assign such benefits to be paid to the above named provider. In the event that my insurance coverage expires or denies payment, I understand that I am personally responsible for all fees incurred.

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.

Signed_____ Dated_____

Printed Name_____

nature works
ACUPUNCTURE & CHINESE MEDICINE

Patient Privacy Disclosure

The information provided below is the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important.

Legal Responsibilities of the acupuncturist: As mandated by Federal and State legal requirements, your protected health information must be protected. .As part of these regulations, the acupuncturist is required to ensure that you are aware of privacy policies, legal duties, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration during the course of practice and will be in effect until it is replaced. The acupuncturist reserves the right to modify privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. The acupuncturist reserves the right to make the modifications effective for all protected health information that the acupuncturist maintain, including protected health information the acupuncturist created or received before the changes were made. Changing the notice will precede all significant modifications. Protected Health Information Use and Disclosure: Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. Treatment: Use and disclosure of your protected health information may be provided to a healthcare provider providing treatment to you. However, this information will not be provided unless you have authorized it in writing. Payment: Your protected health information may be used and disclosed to obtain payment for services the acupuncturist provided to you. Healthcare Processes: The acupuncturist may use and disclose your protected healthcare information in relation to our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing, or credentialing activities. Your Authorization: At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation. Your protected healthcare information may be disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization. Person Involved in Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information may be used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, the acupuncturist will disclose protected health information using her professional judgment, disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. The acupuncturist will use professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled herbal prescriptions. Marketing Health-Related Services: The use of your protected health information for the purpose of marketing is prohibited without your written authorization. Required By Law: Your protected health information may be used or disclosed if required by law. Abuse or Neglect: As required by law, if the acupuncturist has reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If the acupuncturist has reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others, the acupuncturist may have to provide the necessary protected health information. National Security: Under some circumstances, the military may require disclosure of healthcare information for armed forces personnel. For the purpose of national security activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected healthcare information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information. Appointment Reminders: Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, emails, or letters. The acupuncturist may also write a thank you card to whom ever referred you to her practice. Patient Rights Access: With limited exception, you have the right to review your protected health information. Disclose Accounting: Your may choose to request a review of every time the acupuncturist discloses your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years. Restrictions: You may request the acupuncturist apply additional restrictions to any disclosure of your healthcare information. The acupuncturist is not required to respond to the application of these additional restrictions. If the acupuncturist agrees to follow your request regarding additional restrictions, the acupuncturist will follow the agreed restrictions unless an emergency situation dictates otherwise. Alternative Communication: Your may request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications. Electronic: Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well. I HAVE READ THE PATIENT PRIVACY DISCLOSURE AND WAS OFFERED A COPY

Signed_____ Dated_____

nature works
ACUPUNCTURE & CHINESE MEDICINE

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. 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 SIGNATURE _____X (Date)_____
(Or Patient Representative, Indicated Relationship)

Printed Name_____

OFFICE SIGNATURE _____X (Date)_____