ACUMED SPA: NEW PATIENT INTAKE FORM Today's Date _____/_____/_____

PERSONAL INFORMATION:

Name _____ Birthdate _____/_____/_____

Address _____

City _____ State _____ Zip _____

Cell Phone # _____ Work Phone # _____

Email address _____

Referred by _____

Reason For Today's Visit:

1._____

2._____

3._____

How long have you had this condition? _____

Is it getting worse? ☐ yes ☐ no Does it bother your: ☐ Sleep ☐ Work ☐ Other

What seemed to be the initial cause? _____

What makes it better? _____

What makes it worse? _____

FAMILY MEDICAL HISTORY

☐ Allergies ☐ Arteriosclerosis ☐ Asthma ☐ Alcoholism ☐ Depression ☐ Diabetes ☐ Heart Disease
☐ High Blood Pressure ☐ Stroke ☐ Cancer (type) _____

PAST MEDICAL HISTORY

☐ AIDS/HIV	☐ Diabetes	☐ Herpes
☐ Alcoholism	☐ Emphysema	☐ High Blood Pressure
☐ Appendicitis	☐ Epilepsy	☐ Multiple Sclerosis
☐ Arteriosclerosis	☐ Goiter	☐ Mumps
☐ Asthma	☐ Gout	☐ Pacemaker
☐ Birth Trauma	☐ Heart Disease	☐ Pneumonia
☐ Cancer	☐ Hepatitis	☐ Trauma

List all Medical History, including injuries, accidents, surgeries, traumas both physical and emotional, with dates:

_____

_____

_____

Any allergies or sensitivities? _____

DIET

Appetite: ☐ Low ☐ High

☐ Salty Food ☐ Sugary Foods ☐ Artificial Sweeteners ☐ Coffee/Tea ☐ Soda

☐ Vegetarian ☐ Gluten free ☐ Low Carb ☐ Low Fat ☐ Raw Foods

List a typical day's food intake, including meals, snacks and beverages _____

_____

What Medications are you currently taking?

_____

What Supplements are you currently taking?

_____

LIFESTYLE

☐ Stress ☐ Alcohol ☐ Tobacco ☐ Marijuana ☐ Drug Usage ☐ Addictions ☐ Occupational Hazards

Do you Exercise?_____ Frequency_____ Type_____

GENERAL SYMPTOMS

☐ Poor Sleep
☐ Bodily Heaviness
☐ Chills
☐ Fatigue
☐ Lack of Strength
☐ Heavy Sleep
☐ Cold Hands/Feet
☐ Recent Weight Loss/Gain
☐ Poor Circulation
☐ Dream-disturbed Sleep
☐ Fever
☐ Night Sweats
☐ Sweats Easily
☐ Muscle Cramps
☐ Dizziness/Vertigo

HEAD/EYES/EARS/NOSE/THROAT

☐ Eye Strain
☐ Night Blindness
☐ Teeth Problems
☐ Grinding Teeth
☐ TMJ
☐ Face Pain
☐ Eye Pain
☐Myopia/Presbyopia
☐ Gum Problems
☐ Mouth/Lip Sores
☐ Excessive Saliva
☐ Red Eyes
☐ Glaucoma
☐ Sinus Problems
☐ Asthma
☐ Swollen Glands
☐ Throat Lump
☐ Itchy Eyes
☐ Cataracts
☐ Ear Ringing-High/Low
☐ Earaches
☐ Poor Hearing
☐ Headaches
☐ Eye Spots
☐ Migraines
☐ Concussion

RESPIRATORY

☐ Difficulty Breathing
☐ Shortness of Breath
☐ Tight Chest
☐ Asthma/Wheezing
☐ Cough-Wet or Dry?
☐ Coughing Blood
☐ Pneumonia
☐ Bronchitis
☐ Difficulty Inhaling/Exhaling?
Color of Phlegm_____

CARDIOVASCULAR

☐ High Blood Pressure
☐ Low Blood Pressure
☐ Heart Palpitations
☐ Rapid Heart Rate
☐ Fainting
☐ Blood Clot
☐ Chest Pain
☐ Difficulty Breathing
☐ Irregular Heartbeat
☐ Phlebitis

GASTROINTESTINAL

☐ Constipation
☐ Bloating
☐ Black Stools
☐ Intestinal Pain/Cramping
☐ Gas
☐ Vomiting
☐ Mucous in Stools
☐ Rectal Pain
☐ Diarrhea
☐ Nausea
☐ Bloody Stools
☐ Burning Anus
☐ Acid Reflux
☐ Hemorrhoid
☐ Itchy Anus

Bowel Movements- How Often?_____

_____

MUSCULOSKELETAL

☐ Neck/Shoulder Pain ☐ Joint Pain ☐ Lower Back Pain ☐ Limited Use
☐ Mid Back Pain ☐ Muscle Fatigue ☐ Limited Range of Motion ☐ Lack of Strength
☐ Muscle Pain ☐ Rib Pain

SKIN AND HAIR

☐ Rashes ☐ Eczema ☐ Dandruff ☐ Changes in Hair/Skin
☐ Hives ☐ Psoriasis ☐ Itching ☐ Fungal Infections
☐ Ulcers ☐ Acne ☐ Hair Loss ☐ Dry Skin/Hair

NEUROPSYCHOLOGICAL

☐ Seizures ☐ Poor Memory ☐ Irritability ☐ Post-Traumatic Stress
☐ Numbness ☐ Depression ☐ Easily Stressed ☐ Seeing a Therapist
☐ Tics ☐ Anxiety ☐ Abuse Survivor

GENITOURINARY

☐ Painful Urination ☐ Blood in Urine ☐ Venereal Disease ☐ Kidney Stone ☐Premature Ejaculation
☐ Frequent Urination ☐ Unable to Hold Urine ☐ Bed wetting ☐ Increased Libido ☐ Nocturnal Emission
☐ Urgent Urination ☐Incomplete Urination ☐ Wake to Urinate ☐ Decreased Libido ☐ Impotence

GYNECOLOGY

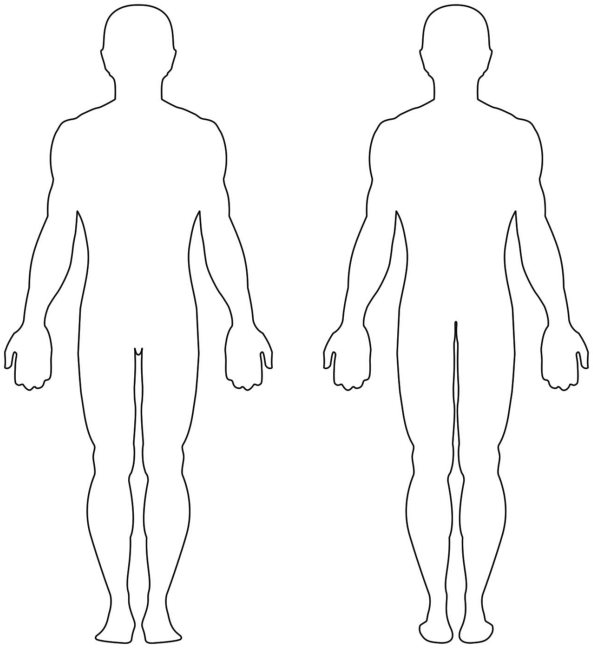
Age Menses Began_____ Duration of Flow_____ Length of Cycle (in a 28 day cycle)_____

☐ Breast Lumps ☐ Irregular Periods ☐ Painful Periods ☐ PMS ☐ Clots ☐ Vaginal Sores ☐ Odor

No. of Pregnancies_____ No. of Live Births_____ No. of Miscarriages_____

Age at Menopause_____ Date of last PAP_____ Date of Last Menses_____

INDICATE AREAS OF CONCERN ON BODY OUTLINE:



ANY OTHER INFORMATION WE MAY NEED TO KNOW:

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 : DATE:

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

AcuMed Spa of Greenville, LLC | Elizabeth A Allen, MS, LAc | 732 Wade Hampton Blvd. Ste. D, Greenville, SC 29609

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 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.
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: DATE:
(Or Patient Representative) (Indicate relationship if signing for patient)

FINANCIAL POLICY

I understand that all appointments that are cancelled within less than 24 hours time, or missed appointments, will be charged full price for the appointment. The following fees will be applied:

Initial Acupuncture Visit - $95 Follow Up Acupuncture Visit - $75

If you are an insurance patient, you will be responsible for any and all charges that the insurance company does not pay. You will be billed for this amount. If appointments have been purchased in advance, the missed or cancelled appointment (outside of 24 hours notice) will be deducted from the number of remaining appointments or gift certificates.

PATIENT SIGNATURE: DATE:

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE