Acupuncture Pain and Performance

430 E. Avenida De Los Arboles #105
Thousand Oaks, CA 91360

PATIENT INFORMATION AND HEALTH HISTORY

General Information

NAME _____ DATE _____

ADDRESS _____

CITY _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

E-MAIL ADDRESS _____

BIRTH DATE _____ AGE _____ GENDER Male

MARITAL STATUS Single SOCIAL SECURITY NUMBER _____

Emergency Information

CONTACT NAME _____ RELATIONSHIP_____

CONTACT'S PHONE NUMBER _____

PRIMARY CARE PROVIDER'S NAME _____

CITY _____ PHONE NUMBER (if known) _____

TYPE OF CARE _____

SECONDARY CARE PHYSICIAN'S NAME(S) _____

Cancellation Policy

Acupuncture Pain and Performance requires that all scheduled appointments be given at least 24 hours notice of cancellation. Failure to provide at least 24 hours notice will be subject to the cancellation charge of **$50.00.**

Initials of Participant or Guardian: _____

Credit Card information

CARD NUMBER _____ TYPE Visa

EXPIRATION DATE _____ SECURITY CODE _____

NAME ON CARD _____

SIGNATURE _____

(Please sign at time of visit)

MEDICAL HISTORY QUESTIONNAIRE

What is your main reason for making this appointment?

When was your last medical exam or check up?

Who referred you to acupuncture?

	Yes	***No***	*Please explain any answer:*
Have you had acupuncture before?	☐	☐	_____
Do you have the tendency to faint?	☐	☐	_____
Do you have a pacemaker?	☐	☐	_____
Do you have Hepatitis A, B, C, D, E?	☐	☐	_____
Are you HIV+?	☐	☐	_____
Do you believe you are pregnant?	☐	☐	_____
Any traumas?	☐	☐	_____
Any accidents?	☐	☐	_____
Any surgeries?	☐	☐	_____

Please further explain any of the answers above:

Family Medical History

Please indicate if any of your blood relatives **now have** or **have had** any of these conditions?

☐ Heart disease	☐ High/low blood pressure	☐ Emotional disorders	☐ Fainting
☐ Irregular heart rhythm	☐ High Cholesterol	☐ Paralysis	☐ Tuberculosis
☐ Chest pain/discomfort	☐ Heart murmurs	☐ Cancer	☐ Obesity
☐ Respiratory disorders	☐ Dizziness/vertigo	☐ Stroke	☐ Diabetes
☐ Excessive Fatigue	☐ Bleeding disorders	☐ Epilepsy	☐ Anemia

Physical Activity History

Please indicate the type and amount of exercise or activity that you do regularly. (What, how long, how often)

Dietary Habits

Please describe how you typically eat. (What, when, how often, food allergies, cravings)

GENERAL MEDICAL HISTORY

Please indicate if you have now or have any of these conditions by marking with a "C" for current and a "P" for past.

Head and Neck
- Dizziness
- Fainting
- Enlarged Lymph glands
- Headaches

Other _____

Ears
- Infection
- Ringing
- Loss of hearing
- Pain

Other _____

Eyes
- Blurred vision
- Changes in vision
- Poor night vision
- Spots or floaters
- Inflammation/stys

Other _____

Nose/throat/mouth
- Bleeding
- Sinus infections
- Allergies
- Sore throat
- Hoarseness
- Changes in taste
- Difficulty swallowing
- Changes in smell
- Ulcers/Canker sores
- Sore/bleeding gums
- Toothaches
- Teeth problems

Other _____

Skin
- Hives
- Rashes
- Allergies
- Eczema
- Psoriasis
- Night sweat
- Excess sweating
- Dryness
- Bruise easily

Other _____

General
- Fatigue
- Thirst
- Changes in appetite
- Poor appetite
- Aversion to cold
- Aversion to wind
- Frequent dreams/nightmares
- Depression
- Agitation
- Irritability
- Anxiety
- History of psychiatric treatment
- Poor memory
- Difficulty concentrating
- Sores that don't heal
- Surgical implants
- Unusual bleeding or discharges
- Jaundice
- Epstein Barr (EBV) or Mononucleosis (Mono)
- Rheumatic fever
- Thyroid disorder
- Cancer
- Anemia
- Lupus

Other _____

Neurological
- Numbness
- Tingling
- Allergies
- Seizures
- Tremors
- Paralysis
- Epilepsy/convulsions

Other _____

Infection History
- Staph
- MRSA
- Gonorrhea
- Chlamydia
- Syphilis
- Genital warts
- Herpes
- TB

Other _____

Gastrointestinal
- Indigestion P
- Nausea
- Bloating
- Stomach pain
- IBS
- Colitis
- Crohn's disease
- Pancreatitis
- Bowel movement change
- Frequent diarrhea
- Frequent constipation
- Dry hard stools
- Soft sticky stools
- Loose stools
- Bloody stools
- Excessive hunger
- Hemorrhoids
- Vomiting blood
- Peptic ulcer
- Recent changes in weight
- Food cravings

Other _____

Cardiovascular
- Palpitations
- Chest pain or tightness
- Rapid heartbeat
- Heart disease
- Poor circulation
- Swollen ankles
- Phlebitis
- Cold hands/feet
- Pacemaker
- Hoarseness
- High blood pressure
- Stroke

Other _____

Respiratory
- Chronic cough
- Coughing up blood
- Coughing up phlegm
- Difficulty breathing
- Wheezing/asthma
- Frequent colds
- Emphysema
- Pneumonia
- COPD

Other _____

Women
- Frequent vaginal infections
- Infertility
- Pain/itching of genitals
- Genital lesions/discharge
- Pelvic inflammatory disease
- Abnormal pap smear
- Irregular periods
- Emotional changes with menses
- Clots in menses
- Painful menstrual cramps
- PMS
- PCOS
- Abnormal bleeding
- Menopausal symptoms
- Breast lumps/cysts
- Breast swelling/pain

Other _____

When was your last period? _____

How many days between periods? _____

Color? _____

Clots? _____

Men
- Pain/itching of genitals
- Genital lesions/discharge
- Impotence
- Premature ejaculation
- Prostate problems
- Infertility

Other _____

Urinary
- Frequent urination
- Frequent UTI
- Weak stream
- Changes in bladder habits
- Kidney disease

How many times do you urinate per day ? 0

How many times do you urinate at night ? 0

Other _____

Please explain any situation above:

Do you have any other condition not listed above? If yes, please state:

MUSCULOSKELETAL MEDICAL HISTORY

Please indicate if you have any of these conditions by marking with a "C" for current and a "P" for past.

General
- Chest pain/discomfort
- Chest Pain with cough
- Pain when coughing
- Pain in the ribs
- Epigastric Pain
- Lower abdominal Pain

Shoulder
- Pain ----
- Pain with movement
- Pain with overhead
- ıovement
- Loss of movement
- Shoulder "gives out"
- Swelling
- Frozen shoulder
- Dislocation
- Tendonitis
- Bursitis
- Rotator cuff

Other _____

Hands/Wrist
- Cold/Hot hands
- Numbness/Tingling
- Loss of grip strength
- __ Pain with movement
- Swelling
- Carpal tunnel
- Arthritis

Other _____

Abdomen
- __ Hernia
- __ Tenderness
- Belly button pain when coughing or sneezing

Upper/Mid Back
- Pain when lifting
- Pain while standing
- Pain while twisting
- Pain as you stand up
- Disk problems
- Degenerative disc
- Herniated
- Stenosis
- Scoliosis
- Spinal fusion

Other _____

Knee
- Pain ----
- Swelling or redness
- Pain with movement
- Loss of flexibility
- Pain bearing weight
- Pain going down stairs
- Pain going up stairs
- Pain or stiffness after sitting for long periods
- Stiff when getting out of bed
- Knee gives out or locks
- Grinding noise or feeling
- Stiff when getting out of bed
- Knee Replacement ----
- Meniscus ----
- MCL/ACL --- ----
- Tendonitis
- Bursitis

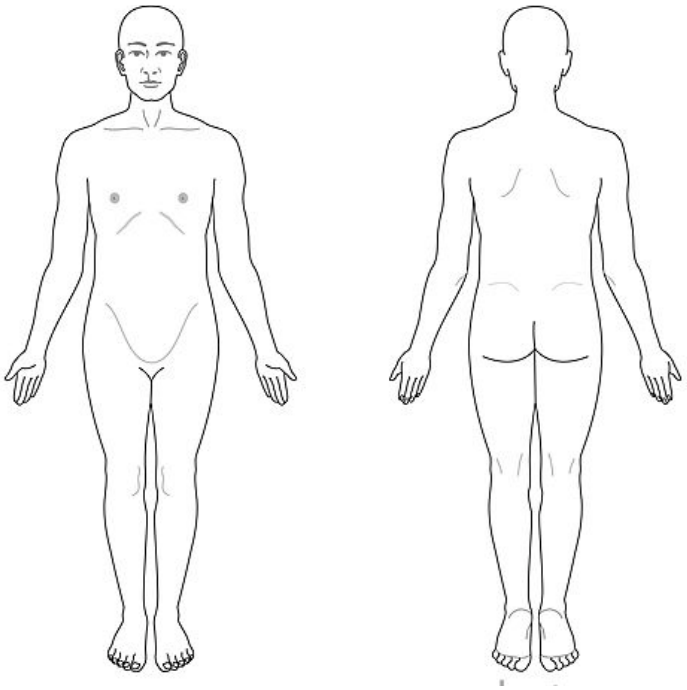
Other _____

Arms/Forearms/Elbow
- Cold/Hot hands
- Numbness/Tingling
- Loss of strength
- __ Loss of movement
- Pain with movement
- Tennis or golfer's elbow
- Psoriasis
- Arthritis
- Fractures or breaks
- Dislocation

Other _____

Low Back
- Sudden pain
- Pain comes on when
- ınstipated
- Pain as you defecate
- Pain radiates to groin
- Pain worse in morning
- Stiff when getting out of bed
- Unable to twist/turn at waist
- Degenerative disc
- Pinched nerves
- Stenosis
- Sciatica
- Herniated
- Spinal fusion

Other _____



Rate your pain

(Mild) ***1 2 3 4 5 6 7 8 9 10*** (Severe) Rate Severity

Quality of pain

Rate Quality of Pain □ ***Other*** _____

Neck
- Pain with movement
- Pain with tilting
- Pain with twisting
- Whiplash
- Loss of flexibility
- Stiff getting out of bed
- Stiff neck
- Grinding/popping noise
- Degenerative disc
- Pinched nerves
- Stenosis
- Herniated
- TMJ
- Spinal fusion

Other _____

Hips/Pelvis/Legs
- Hernia
- Fractures or breaks
- Dislocation
- Hip Replacement
- Groin pain with coughing
- Stiff when getting out of bed

Other _____

Feet/Ankles
- Psoriasis
- Numbness/Tingling
- Sprained ankle
- Arthritis
- Achilles tendonitis
- Fractures or breaks

Other _____

Please further explain any situation stated above:

Do you have any other condition not listed above? *Please explain:*

MEDICATIONS

Please list all medications, herbal supplements, nutritional supplements, or vitamins and minerals that you take regularly as well as the reason why you are taking them.

Date:	Medication:	Reason:	Dose and How often:		Date of last dose:	Prescribed by:	Start date:

NOTICE OF PRIVACY POLICIES

This office is dedicated to providing services for your health and protecting your privacy. This notice will remain in effect until it is replaced or amended by changes in the law.

Personal Information is gathered from you in the following ways:
Information received from you.
Information received from other healthcare providers.

This information is used for the purposes of treatment, payment and healthcare operations. This office will use and disclose information about you only for those purposes.

You may specifically authorize us to use protected health information (PHI) for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosure will be made to any entity that you choose to have your protected health information.

Marketing
This office will not use your health information for marketing communications without your written authorization. However, this office may send birthday cards, newsletters or appointment reminders, by telephone, email, or mail. Please inform us if you do not want us to contact you for any of the above reasons. We do **NOT** sell your information or share your information with unrelated companies.

Disclosure
This office may use or disclose your PHI when required by law.

Patient Rights
Upon written request, you have the right to access, review, or receive copies of your healthcare records.
For paper copies there is a copy fee of $0.25 per page and this office will need 10 working days to process it.
Upon written request you have the right to receive a list of items this office has disclosed.
You have the right to request that this office place additional restrictions on disclosure of your PHI.
You have the right to request that we amend your PHI; this request must be submitted in writing.
You have a right to receive all notices in writing.

If you have questions, complaints, or want more information, please contact the office. Send written complaints to the U.S. Department of Health and Human Services.

Acknowledgement of Receipt of the Notice of Privacy Practices

I, (print full name) _____, have read, reviewed, understand and agree to the statement of the Notice of Privacy Policy for healthcare services in this acupuncture office, Acupuncture Pain and Performance.

_____ _____
Date **Signature of Patient or Personal Representative (Please sign at time of visit)**

_____ _____
Time **Print Name**

Description of Personal Representative's Authority:

_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, (print full name) _____, with my consent, Acupuncture Pain and Performance or David Ito may use and disclose my protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO) when applicable. Please refer to Acupuncture Pain and Performance's Notice of Privacy Practices for a more complete description of such uses and disclosures.

The PHI is any information that includes, but is not limited to:
-Demographics information.
-Information gathered by this practice as it relates to my past, present, and future physical or mental health.
-Information gathered by this office for past, present, and, future payments for providing healthcare services.
-Healthcare operations purposes will include quality assessment activities, business management and other general operations, procedures, or activities.

I have the right to review and have read the Notice of Privacy of Practices prior to signing this consent. Acupuncture Pain and Performance reserves the right to revise its Notice of Privacy of Practices at any time.

With my consent, Acupuncture Pain and Performance or any of its agents my call my home or any other designated location and leave a message on a voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointments, and any call pertaining to my clinical care, including laboratory results amongst others.

With my consent, Acupuncture Pain and Performance or any of its agents may mail to my home or any other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are clearly marked personal and confidential.

With my consent, Acupuncture Pain and Performance or any of its agents may email me appointment reminders and patient statements. I have the right to request that Acupuncture Pain and Performance or any of its agents restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Acupuncture Pain and Performance or any of its agents to use and disclosure of my PHI to carry out TPO.

I understand that I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Acupuncture Pain and Performance or any of its agents may decline to provide me treatment.

(Please sign at time of visit)

_____ _____

Date **Signature of Patient or Personal Representative**

_____ _____

Time **Print Name**

Description of Personal Representative's Authority:

_____

OFFICE POLICIES SUMMARY

Welcome to Acupuncture Pain and Performance. Our goal is to make you comfortable and give you the best care possible. At any time, please do not hesitate to ask any questions that you might have regarding your visit, your billing, or about any of our policies.

FEES The fees charged in this office are comparable to those charged by other healthcare providers in this area with similar qualifications. Please ask to see our fee schedule. We except cash, credit cards, and personal checks. Please note, there will be a $25 charge for any returned check.

If we bill your insurance and acupuncture coverage is denied, we will notify you of the amount due. If we are unable to contact you regarding fees for services due, your credit card will be charged after 14 days.

Initials: _____

INSURANCE COVERAGE Many insurance policies cover acupuncture, but we do not claim that yours does. Policies can differ greatly in terms of deductible and percentage of coverage for acupuncture. We can verify coverage and submit your claim form for reimbursement, provided you sign the financial agreement below.

Initials: _____

RELEASE OF INFORMATION Your insurance company may require medical reports to document our treatment and progress. Your initials below authorize the release of medical information necessary to process your insurance claim.

Initials: _____

CANCELLATIONS As a courtesy to our office and other patients, we ask that you please notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment. You will be charged a $50.00 fee for any missed appointment or any cancellation with less than 24 hours notice.

Initials: _____

ASSIGNMENT OF BENEFITS (If you have insurance other than Blue Cross) With the signature below, I give permission for my insurance company to assign benefits and send payment directly to David Ito, L.Ac, at 430 E. Avendia De Los Arboles #105, Thousand Oaks, CA 91360 for acupuncture services that have been provided to me.

Initials: _____

FINANCIAL AGREEMENT ASSIGNMENT OF BENEFITS

I, (print your full name) _____, am receiving or about to receive healthcare services in this office. I understand that I am responsible to pay all non-insurance related fees when services are rendered, including herbs, etc. If I choose to use my insurance, I understand that I will be responsible for all "non-covered" services and/or coinsurance/co-pays associated with my office visit. In addition, I also authorize insurance payments of medical benefits to Acupuncture Pain and Performance and/or David Ito.

By signing below, I agreed to comply with the office policies stated above which I have read and understood. I also authorize the use of my signature below on all insurance submissions.

(Please sign at time of visit)

_____ _____

Date **Signature of Patient or Personal Representative**

_____ _____

Time **Print Name**

Description of Person Representative's Authority:

_____

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.

(Please sign at time of visit)

ACUPUNCTURIST NAME: **David Ito, L.Ac (CA 14936)**

(Date)

PATIENT SIGNATURE **X**

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

ALSO **SIGN** THE **ARBITRATION AGREEMENT** ON **REVERSE** SIDE

PATIENT NAME:

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 California 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 the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). 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.

(Please sign at time of visit)

	(Date)
PATIENT SIGNATURE **X**	
(Or Patient Representative)	(Indicate relationship if signing for patient)
	(Date)
OFFICE SIGNATURE **X**	

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE