HOLISTIC HARMONY
HOLISTIC WELLNESS CENTER

Health History

for Acupuncture Initial Appointment

Today's Date_____

Full Name_____ Preferred Name_____ Date of Birth_____

Gender_____ Pronouns_____ Marital Status_____Phone _____

Email_____Street Address_____

Emergency Contact Name_____ Phone _____Relationship_____

Primary Physician Name_____ Phone_____

Occupation / Employer / School _____

Is this your first experience with Acupuncture? ____Yes _____No

How did you learn about Acupuncture at Holistic Harmony? _____

PRIMARY HEALTH CONCERNS

Please describe the health concerns you would like to address with Acupuncture and briefly describe.

1._____

2._____

3._____

MEDICATIONS/SUPPLEMENTS

Please list all current medications and supplements, both prescription and over-the-counter, dose, frequency, and when you began taking them. If none, please indicate so:

_____

_____

_____

_____

_____

ALLERGIES/NUTRITION

Please list any known allergies or food sensitivities. If none, please indicate so:

_____

_____

Please list any special diet you have (i.e. low carb, vegan, vegetarian, gluten-free, etc.)

_____

SOCIAL HISTORY

Do you use any of the following substances? __Coffee/soda/caffeine __Alcohol __Cigarettes __Marijuana

__Recreational drugs ___Opioids If so, how frequently_____

Do you exercise regularly? If so, what and how often? _____

_____

Health History (con't)

SURGERY/SIGNIFICANT INJURY HISTORY

Please list any past surgeries, injuries or hospitalizations:

_____

_____

_____

SIGNIFICANT ILLNESS / FAMILY HISTORY

Do you or does anyone in your biological family (mother, father, siblings, grandparents, children) have a history of the following? Indicate all that apply:

	You	Family		You	Family
Arthritis	☐	☐	Asthma/COPD	☐	☐
Autoimmune	☐	☐	Anemia/Blood	☐	☐
Cancer	☐	☐	Diabetes	☐	☐
Drugs/Alcohol	☐	☐	Disordered Eating	☐	☐
Trauma/Abuse	☐	☐	Heart Disease	☐	☐
Hepatitis	☐	☐	Hypertension	☐	☐
IBS	☐	☐	Kidney Disease	☐	☐
Depression	☐	☐	Seizure Disorder	☐	☐
Stroke	☐	☐	Thyroid Disease	☐	☐

GENERAL HEALTH: Please indicate all that you have experienced in the past 6 months:

TEMPERATURE:

___Absence of thirst ___Chills ___Cold hands/feet ___Cold "in bones" ___Excessive thirst ___Hot at night ___Hot hands/feet/chest ___Feverish feeling ___Night sweats ___Unusual sweats

ENERGY:

___Decreased energy after eating ___Decreased energy during the day ___Fatigue ___Wired or ungrounded feeling ___Easily tired ___Unexplained weight loss ___Unexplained weight gain

SLEEP:

___Difficulty falling asleep ___Waking during night ___Disturbing dreams ___Light sleeper ___Heavy Sleeper ___Restless sleep ___Not rested upon waking ___Vivid dreams

SKIN & HAIR

___Cysts/tumors ___Dry, brittle nails ___Dry hair ___Dry lips ___Dry skin ___Eczema ___Itching skin ___Pimples/Acne ___Rashes

EYES:

___Blurred vision ___Recent vision changes ___Poor night vision ___Floating spots ___Cataracts ___Glasses/Contacts ___Dry eyes ___Red eyes ___Itchy eyes

HEAD:

___Dizziness ___Vertigo ___Inability to concentrate ___Poor memory ___Forgetfulness ___Unclear/cloudy thinking ___Concussion ___Headaches ___Migraines ___Nausea with headaches

Health History (con't)

EMOTIONS (Please check those that predominate your life):

___Anger ___Irritability ___Anxiety ___Worry ___Obsessive thinking ___Sadness ___Grief
___Depression ___Joy ___Fear ___Timidness/shyness ___Indecisiveness ___Easily stressed ___Thoughts of suicide
___Treated for emotional health

EARS/NOSE/THROAT:

___Frequent ear infections ___Ringing in ears ___Decreased hearing ___Nose bleeds ___Sinus infections
___Hay fever or allergies ___Recurring sore throats ___Difficulty swallowing ___Phlegm in throat ___Frequent colds/flu
___Frequent upper respiratory issues ___Dry mouth ___Bleeding gums ___Tooth problems ___Grinding teeth

CHEST/LUNGS/HEART:

___High blood pressure ___Low blood pressure ___Palpitations ___Pacemaker ___Chest Pain/Discomfort
___Chest tightness ___Irregular Heart Beat ___Murmur ___Fainting ___Frequent sighing ___Shortness of breath
___Difficult breathing ___Weak Voice ___Cough ___Coughing blood ___Production of phlegm

MUSCULAR-SKELETAL

___Neck/shoulder pain ___Low back pain ___Mid back pain ___Upper back pain ___Muscle spasm/twitch/cramps
___Sore, cold, or weak knees ___Joint pain ___Muscle weakness ___Swelling of hands/feet ___Numbness/tingling of limbs
___Paralysis ___Bleed or bruise easily ___Feeling of body/limb heaviness/weakness ___Varicose veins

GENITO-URINARY:

___Kidney stones ___Frequent urination ___Pain/burning with urination ___Urgency to urinate ___Waking to urinate
___Difficult to stop/start urination ___Weak urinary stream ___Incontinence/unable to hold urine ___Dark urine ___Pale urine

GASTRO-INTESTINAL:

___Bad breath ___Belching ___Bloating ___Blood in stool ___Constipation ___Dry Mouth ___Dry stool
___Diarrhea ___Excessive appetite ___Foul-smelling stools ___Gas ___Hemorrhoids ___Hernia
___Indigestion/heartburn ___Loose stools ___Low appetite ___Nausea ___Vomiting ___Pain/cramps in abdomen
___Pain with bowel movement ___Prefer cold drinks ___Prefer warm drinks ___Rectal pain ___Thirsty all the time
___Thirst w/ no desire to drink ___Tired after bowel movement

ALL PATIENTS:

Is there anything else you would like to share about your health?

_____

_____

_____

_____

_____

_____

Health History (con't)

FEMALE PATIENTS:

Are you currently pregnant? ___Yes ___No ___Maybe Are you currently breastfeeding? ___Yes ___No

Are you in peri-menopause, menopause, or post-menopause? ___Yes ___No Which?_____

Are you currently using birth control? ___Yes ___No If yes, which type? _____

Start date of last period _____ Average length of flow (i.e. 5 days)_____

Average length of full cycle (i.e. 28 days)_____ Age at first menses_____

Indicate ALL that apply to you:

___Heavy blood flow ___Medium blood flow ___Light blood flow ___Painful periods ___Irregular cycle

___Flow contains blood clots ___Bright red blood ___Brown blood ___Dark red blood ___Pale red blood

___Purple blood ___Watery blood ___Cramping before period ___Cramping during period ___Cramping after period

___Ovulation cramping ___Breast distention/tenderness ___Bloating ___Water retention ___Nausea with periods

___Excessive vaginal discharge ___Pain/Itching of genitals ___Frequent vaginal infections ___Abnormal pap smear

___Pain with intercourse ___Mood changes ___Low libido ___Breast lumps ___Ovarian cysts ___Vaginal dryness

___Digestive changes during cycle ___Mid-cycle spotting ___Headaches during cycle ___Infertility ___Endometriosis

___Uterine fibroids ___PCOS ___Vulvar varicosities ___Hot flashes ___Night sweating

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropnate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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 appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

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, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). 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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

PATIENT NAME:

ACUPUNCTURIST NAME: **Balance Point Acupuncture, LLC / Holly Owens, L.Ac.**

(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 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. 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 healthcare 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 healthcare provider and/or other licensed healthcare 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 healthcare provider, including those working at the healthcare 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 healthcare provider, and/or the healthcare 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) and provide National Arbitration and Mediation ("NAM") with the party arbitrator's contact information within thirty days of the date Respondent files its initial responsive pleading. A third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties from a list of arbitrators supplied by National Arbitration and Mediation ("NAM") within thirty days thereafter. The list supplied by NAM shall be a list of between 5 and 10 arbitrators, depending upon availability. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal 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 damages 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, where not in conflict with this agreement, the Healthcare Malpractice Dispute Resolution Rules and Procedures of NAM shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of NAM rules are available on its website at https://www.namadr.com or by calling 1-800-358-2550 to request a copy of the rules.

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 healthcare 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: Balance Point Acupuncture, LLC Signature: _____ Date: _____

Holly Owens, L.Ac.

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE