SAGE MOUNTAIN
ACUPUNCTURE

ACUPUCTURE NEW PATIENT

Confidential Health History Questionnaire Date:_____

We look forward to helping you achieve your health goals. Please help us learn more about you so that we may provide you with the most effective care. On this questionnaire, you will find many in-depth questions; each answer provides important information that allows us to optimize your health care results. Thank you for your thorough responses.

Last Name	First Name	Middle Initial	Pacemaker or Electrical Devices?

Street Address	City	State	Zip

Home Phone	Cell Phone	Permission to text your appointment reminders? Yes No	Age	Sex	Date of Birth

Marital Status	Employer & Occupation	Emergency Contact: Name & Phone

Height	Weight	Blood Pressure	Date of BP Reading	Blood Type

E-mail Address (for newsletters & appointment reminders)	How did you hear about us?

Are you currently under Doctor's care?	MD's Name	MD's Phone

List your reasons for today's visit, in order of importance.

What treatments have you tried or are you currently doing for these conditions?

Check if you have a FAMILY HISTORY of any of these:

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy / Seizures
- ☐ Glaucoma
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Mental illness
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Other inheritable disease

Please identify current symptoms by marking the box under the "Now" column.
Mark the "Past" column only if a past condition was particularly severe or significant.

Past	Now	
☐	☐	Abdominal / stomach pain
☐	☐	Abnormal appetite
☐	☐	Nausea / vomiting
☐	☐	Belching
☐	☐	Heartburn / reflux
☐	☐	Gas
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Black stool
☐	☐	Blood in stool
☐	☐	Mucous in stool
☐	☐	Undigested food in stool
☐	☐	Rectal pain / hemorrhoids
☐	☐	Regular laxative use
☐	☐	Unusually thirsty
☐	☐	Overweight
☐	☐	Weight changes

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☐	☐	Bleeding / bruising easily
☐	☐	Bleeding gums
☐	☐	Poor circulation
☐	☐	Dizzy spells or fainting
☐	☐	Chest pain / pressure
☐	☐	Irregular heartbeat
☐	☐	Palpitations / chest fluttering
☐	☐	Pounding heartbeat
☐	☐	Racing heartbeat

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☐	☐	Chronic cough
☐	☐	Coughing blood
☐	☐	Frequent chest colds
☐	☐	Shortness of breath
☐	☐	Tightness of chest
☐	☐	Wheezing
☐	☐	Coughing up Phlegm

Color of Phlegm_____

_____

☐	☐	Chronic or recurrent infection
☐	☐	Fatigue or tiredness
☐	☐	Sudden energy drop at _____
☐	☐	Frequent antibiotic use

Past	Now	
☐	☐	Chills
☐	☐	Fever
☐	☐	Excessive sweating
☐	☐	Lack of perspiration
☐	☐	Hot flashes
☐	☐	Night sweats
☐	☐	Cold Hands/Feet/Nose
☐	☐	Tendency to be too hot
☐	☐	Tendency to be too cold

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☐	☐	Dry eyes
☐	☐	Eye pain
☐	☐	Itchy eyes
☐	☐	Tearing eyes
☐	☐	Poor vision
☐	☐	Night or color blindness
☐	☐	Earaches
☐	☐	Ringing or sounds in ears
☐	☐	Hearing problems
☐	☐	Sinus problems
☐	☐	Sneezing
☐	☐	Snoring
☐	☐	Nose bleeds
☐	☐	Dry mouth or throat
☐	☐	Sore throat
☐	☐	Swollen glands
☐	☐	Frequent hoarseness
☐	☐	Mouth or lip sores
☐	☐	Many cavities or root canals
☐	☐	Unusual taste in mouth
☐	☐	Teeth grinding or clenching
☐	☐	Jaw Problems or TMJ
☐	☐	Facial pain
☐	☐	Headaches

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☐	☐	Blood in urine
☐	☐	Burning or painful urination
☐	☐	Difficult urination / retention
☐	☐	Frequent or urgent urination
☐	☐	Frequent urination at night
☐	☐	Loss of bladder control

Past	Now	
☐	☐	Anger
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Fear
☐	☐	Frustration
☐	☐	Grief or sadness
☐	☐	Irritability
☐	☐	Mood swings
☐	☐	Obsession
☐	☐	Panic Attacks
☐	☐	Stress
☐	☐	Worry

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☐	☐	Victim of Child Abuse
☐	☐	Victim of Domestic Abuse
☐	☐	Victim of Sexual Abuse
☐	☐	War Veteran

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☐	☐	Acne pimples
☐	☐	Dry skin / Oily Skin
☐	☐	Itching or burning skin
☐	☐	Skin rash or sores
☐	☐	Tendency to get hives
☐	☐	Scalp itching or flaking
☐	☐	Early graying of hair
☐	☐	Loss of hair
☐	☐	Nail fungus
☐	☐	Weak / brittle nails

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☐	☐	Numbness or tingling
☐	☐	Poor concentration
☐	☐	Poor memory
☐	☐	Seizures or convulsions
☐	☐	Shaking or trembling
☐	☐	Stuttering or stammering

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☐	☐	Difficulty falling asleep
☐	☐	Waking up frequently
☐	☐	Wake up still tired
☐	☐	Many dreams
☐	☐	Nightmares

LIFESTYLE & DIET

☐ Tobacco ☐ E-Cigarettes ☐ Marijuana ☐ Coffee (amt): _____ ☐ Tea (amt):_____ ☐ Soft Drinks (amt):_____ ☐ Energy Drinks (amt) _____ ☐ Alcohol (amt): _____ ☐ Water (amt): _____	☐ Recreational Drugs ☐ High Stress ☐ Occupational Hazards ☐ Artificial Sweeteners ☐ Fast Food ☐ Vegetarian/ Vegan ☐ High Protein ☐ Gluten-free ☐ Low Fat ☐ Crave Sugar ☐ Crave Salt	Exercise: (describe) Herbs/Vitamins/Supplements: (list)

FOR MEN

Past Now	Past Now
☐ ☐ Genital pain, swelling or itching ☐ ☐ Abnormal sex drive [ ] high [ ] low ☐ ☐ Erectile dysfunction	☐ ☐ Low sperm count / motility / morphology ☐ ☐ Penile discharge ☐ ☐ Prostate problem (PSA reading:_____)

FOR WOMEN

Past Now	Past Now	Past Now
☐ ☐ Abnormal PAP smear ☐ ☐ Abnormal sex drive ☐ ☐ Abortion history ☐ ☐ Bleeding between periods ☐ ☐ Breast lumps / tenderness ☐ ☐ Clots in menstrual blood ☐ ☐ Difficulty conceiving	☐ ☐ Endometriosis ☐ ☐ Fibroids ☐ ☐ Genital pain, swelling or itching ☐ ☐ Heavy bleeding with periods ☐ ☐ Hysterectomy ☐ ☐ Menopausal symptoms ☐ ☐ Miscarriage	☐ ☐ Ovaries removed ☐ ☐ Pain with intercourse ☐ ☐ Painful periods ☐ ☐ Pelvic inflammatory disease ☐ ☐ Polycystic ovary disease ☐ ☐ Premenstrual tension / PMS ☐ ☐ Vaginal discharge or dryness

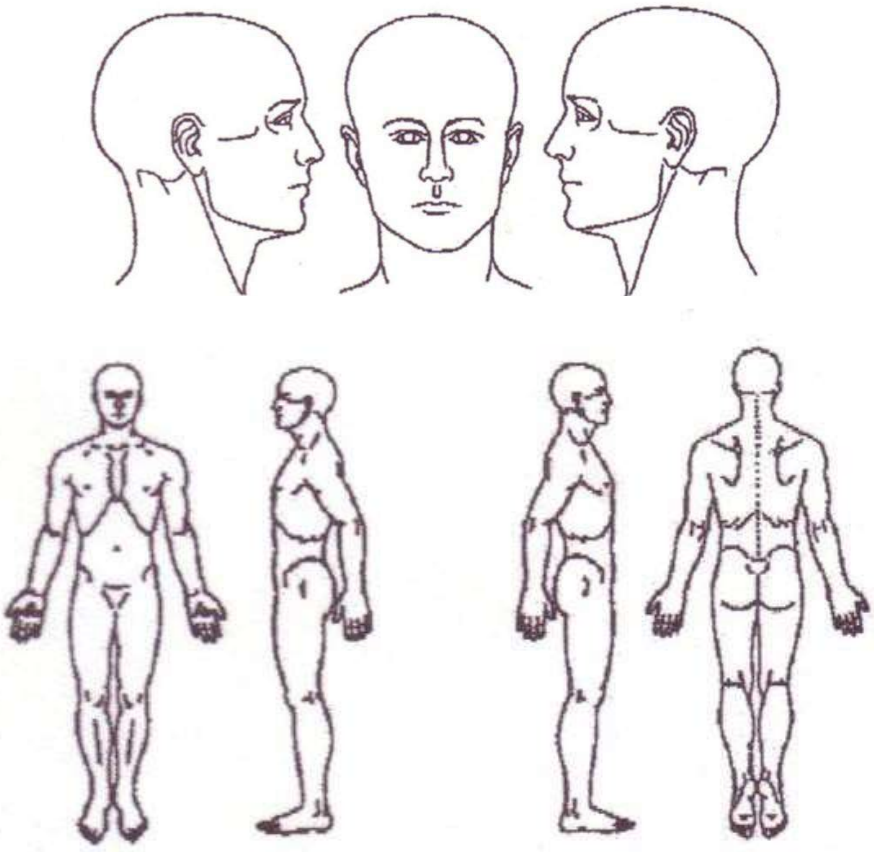
Are you currently pregnant or trying to become pregnant?	
Duration of periods:	Number of pregnancies you've had:
Interval between periods (onset to onset):	Number of births you've had:
Dates of last period:	Ages of your children:
Past birth control methods:	Current birth control method:

Check if you have or had any of these:

Past Now	Past Now	Past Now
☐ ☐ Addiction (to _____) ☐ ☐ AIDS / HIV ☐ ☐ Allergies (to _____) ☐ ☐ Anemia ☐ ☐ Arthritis ☐ ☐ Asthma ☐ ☐ Bleeding disorder ☐ ☐ Blood clots ☐ ☐ Bronchitis ☐ ☐ Cancer / tumor ☐ ☐ Cataracts ☐ ☐ Chicken pox ☐ ☐ Chronic fatigue syndrome ☐ ☐ Colon / bowel disease ☐ ☐ Diabetes ☐ ☐ Emotional / mental illness ☐ ☐ Emphysema	☐ ☐ Epilepsy / Seizure disorder ☐ ☐ Gall bladder disease / stones ☐ ☐ Glaucoma ☐ ☐ Gout ☐ ☐ Gum disease ☐ ☐ Heart disease ☐ ☐ Hepatitis or jaundice ☐ ☐ Herpes ☐ ☐ High / Low blood pressure ☐ ☐ High cholesterol ☐ ☐ Kidney stones ☐ ☐ Kidney or bladder infection ☐ ☐ Liver disease ☐ ☐ Lupus ☐ ☐ Malaria ☐ ☐ Measles, Mumps or Rubella ☐ ☐ Mononucleosis	☐ ☐ Multiple sclerosis ☐ ☐ Osteoporosis / osteopenia ☐ ☐ Pacemaker ☐ ☐ Parkinson's ☐ ☐ Pneumonia ☐ ☐ Polio ☐ ☐ Rheumatic or Scarlet fever ☐ ☐ Shingles ☐ ☐ Spinal meningitis ☐ ☐ Stroke ☐ ☐ Tuberculosis ☐ ☐ Thyroid trouble or goiter ☐ ☐ Ulcer ☐ ☐ Varicose veins ☐ ☐ Venereal disease Other:

Surgeries, hospitalizations & dates:	Accidents, injuries & dates:	Medications, reasons & dosages:
		_____ _____ _____ _____ _____ _____ _____

Please Indicate Areas of Pain or Discomfort:



Severity	**Severity**
☐Back pain or trouble ---------- 1 2 3 4 5 ☐Muscle pain, spasm, cramping - 1 2 3 4 5 ☐Muscle weakness ---------- 1 2 3 4 5 ☐Restless or nervous legs ---------- 1 2 3 4 5	☐Spinal disc problems ---------- 1 2 3 4 5 ☐Stiff or painful neck ---------- 1 2 3 4 5 ☐Swelling ---------- 1 2 3 4 5 ☐Tendonitis (where:_____)

Please describe your pain/discomfort:

_____

_____

_____

_____

_____

_____

Is there anything else you need to tell us?

By signing, I attest that all information I have provided on this Health History is true, accurate and complete. I understand that if I wish to change the dosages of my medications, K. Planinz recommends that this happen gradually and with consent of my prescribing physician(s). I know K. Planinz does not treat cancer or epilepsy.

Sign:	**Date:**

SAGE MOUNTAIN
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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 appropriate 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.

PATIENT NAME:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

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

SAGE MOUNTAIN
ACUPUNCTURE

ARBITRATION AGREEMENT

PATIENT NAME:

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 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 y 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.

(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