JEAN DRUMMOND, L.Ac.
25431 Cabot Road • Laguna Hills, CA 92653 • 760-914-1639

NAME: ____ **DATE:** ____________________

PATIENT CONFIDENTIAL INFORMATION:

Mailing Address: ______________________________ City:________________ State:_____ Zip:________

Home Phone: ______________________________ Cell Phone: ______________________________

E-mail Address: ______________________________

Sex: M____ F____ Marital Status:________________ Date of Birth: ________________Age:__________

Occupation: ______________________________

Employers Name: ______________________________ Address: ______________________________

City: __________________________ State: ________ Zip:______________ Phone:________________

In case of emergency, call: ___________________________ Phone: ____________________

Is this your first acupuncture treatment? Yes____ No___ Who referred you to this office? __________________

Cancellation Policy / No-Shows
Your appointment time is reserved just for you. A late cancellation or no shows leaves a hole in the schedule that could have been filled by another patient. As such, we require 12 hours notice for any cancellations or changes to your appointment. Patients who provide less than 12 hours notice will be charged as one full session. No shows will be charged as one full session. I am aware of the Cancellation and No Show Policy. Initial: _____

Notice of Privacy Practices for Protected Health Information
I acknowledge that my doctor acts in strict accordance with HIPPA regulations and that I may request my own copy of the doctor's Notice of Privacy Practices for Protected Health Information at any time. Initial: ___

Payment Policies:
The fees for office visits are payable at the time of visit, except in certain cases where arrangements have been made with our office. If requested, you can be provided with a receipt so you may bill your insurance company directly. However, we cannot render service on the assumption that our charges will by paid by an insurance company. All professional services are charged directly to the patient. All prepaid packages must be used in a timely manner and will expire in one year from the date of purchase. Initial:____

____ ____________________

Signature of Patient Date

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NAME: ______________________ **DATE:** ______________

HEALTH HISTORY

What is your chief complaint today?

____

What are your biggest health challenges?______________________

____

Check the following conditions you currently have or have experienced:

MUSCULOSKELETAL
____ Back pain
____ Neck/shoulder pain
____ Joint pain & stiffness
____ Arthritis
____ Muscle spasms/cramps
____ Muscle weakness
____ Cold hands & feet

RESPIRATORY
____ Frequent colds & flus
____ Persistent cough
____ Wheezing
____ Phlegm/mucous production
____ Sinus problems/congestion
____ Allergies/Hay fever

CARDIOVASCULAR
____ Palpitations/Irregular heart beats
____ Chest pains
____ High/Low blood pressure
____ Swelling in ankles

EYES/EARS/SKIN
____ Red/inflamed eyes
____ Dry or teary eyes
____ Blurry vision
____ Ringing in ears
____ Skin rashes/Itchy skin
____ Hair loss
____ Bruise easily
____ Eczema/psoriasis
____ Acne

GASTROINTESTINAL
____ Gas & bloating
____ Heartburn/Acid Reflux
____ Nausea & Vomiting
____ Lack of appetite
____ Diarrhea/Loose stools
____ Constipation
Bowel movements
How often? ______________
Is this a change? ______

NEUROLOGIC
____ Headaches
____ Poor memory
____ Lack of concentration
____ Numbness or tingling
____ Dizziness

UROGENITAL
____ Frequent night urination
____ Inability to hold urine
____ Frequent UTI infections

ENDOCRINE
____ Hypothyroid
____ Heat or cold intolerance
____ Excessive thirst or hunger

REPRODUCTIVE
Date of last menses ____________
Average number of days _________
Length of cycle __________
____ Irregular menstruation
____ Menstrual cramps & pain
____ Excessive bleeding
____ Fibroids
____ PMS symptoms
____ Peri/Menopausal symptoms
____ Night sweating
____ Hot Flashes
____ Difficulty conceiving
___ Are you now pregnant?
Number of pregnancies ________

EMOTIONAL
Do you often experience:
____ Insomnia
____ Irritability
____ Frequent anger
____ Depression
____ Cry frequently
____ Mood swings
____ Anxiety or nervousness
____ Stress & tension
____ Difficult to express emotions

MEDICAL HISTORY

Please indicate whether you currently have or have had any of the following conditions:
___ Tumor or cancer
___ Heart disease or heart attack
___ High blood pressure
___ Diabetes
___ Thyroid disorder
___ Asthma
___ Stroke
___ Arthritis
___ Autoimmune disease
___ Herpes simplex
___ Epstein Barr virus
___ HIV virus
___ Anemia
Other: ____________________

Family History:
Has any blood relative had any of the following: Father (F), Mother (M), Brother (B), Sister (S):
______ Stroke
______ High Blood Pressure
______ Heart Disease
______ Cancer
______ Tuberculosis
______ Diabetes
______ Osteoporosis
______ Alzheimer's

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NAME: ________________________________ **DATE:** ____________________

MEDICAL HISTORY

Surgeries/Hospitalizations: *Please list all previous operations and approximate date of the procedure:*

Other serious illnesses, injuries, or fractures:

Allergies: *Please list any foods, drugs or other allergens:*

Current Medications: *Please list prescription or over the counter medications:*

Vitamins & Supplements: *Please list any vitamins, minerals, herbs, etc.*

On a scale of 1-10 (10 being best), how would you rate your overall physical health? ___ Emotional health? ___ Mental health?______

Describe your current stress levels:

____

____

Describe any past stress, incidents or traumas that may have impacted your health:

____

____

____

____

NUTRITION/LIFESTYLE

Current weight: _______________

Height: ______________________

Do you smoke cigarettes? _______

Use recreational drugs? _________

How often do you exercise?

____

What kind of exercise?

____

____

How much coffee do you drink daily?

____

Do you eat lots of sweets and/or carbohydrates? ___ Yes ___ No

Food cravings:
___ Sugar ___Chocolate
___Desserts ___ Breads ___ Dairy
___Fried Foods ___ Alcohol ___
Other____________

Number of alcoholic drinks per week?____ What kind? __________

How much water do you drink daily? _______ oz

On average, how many hours of sleep do you get nightly? ______

Trouble falling asleep? ___ Staying asleep? _____ and/or Wake up frequently? ______

What kind of sleeping aids do you use? ___________________________

____

NUTRITION/LIFESTYLE

Describe your energy levels:

Morning: __________________

Afternoon: _________________

Evening: ___________________

Do you consume sugar or caffeine during the day to help boost your energy? Yes__ No__

Do you enjoy what you do for a living? _________________________

What are some of your interests, hobbies or passions?

____

____

What are your biggest stressors?

____

____

How often do you get outside in nature? _______________________

What things do you do for self-care?

____

____

____

How often do you do self-care?

____

Are willing to commit to your own healing process and the time it can take? ___________

Patient's Name: ____

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 named 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 be 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.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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.

Signature of Patient X____ Date: ______________
(or patient's representative. Indicate relationship or authority of representative):

Print Name of Patient: ____

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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 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, 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 or preceptorship 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.

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 tor 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 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)

OFFICE SIGNATURE: ____ Date: ______________