New Patient Intake Form

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. If you have questions, please ask. Thank you.

Personal Information

Name _____ Date _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Email _____ Work/Cell Phone _____

SS#_____ Sex: Male/Female D.O.B._____ Age _____ Height_____ Weight_____

Marital Status (circle one): Married Single Divorced Widowed Partnered Number of Children _____

Occupation _____ Person Responsible for your Account _____

Emergency Contact: Name _____Phone _____

Have you received acupuncture before? (Circle one): Yes/ No When? _____ With Whom? _____

Who should we thank for referring you to our office _____

Please indicate any significant illnesses you or a blood relative (Grandparent, parent, sibling) have had:

Illness	**You**	**Your Relative**	**Approx. Date**	**Illness**	**You**	**Your Relative**	**Approx. Date**
Cancer	_____	_____	_____	Diabetes	_____	_____	_____
Hepatitis	_____	_____	_____	Heart Disease	_____	_____	_____
High Blood Pressure	_____	_____	_____	Seizures	_____	_____	_____
Rheumatic Fever	_____	_____	_____	Emotional Prob.	_____	_____	_____
Infectious Diseases	_____	_____	_____	Tuberculosis	_____	_____	_____

Please list any medications & Supplements you are currently taking:

Medicine Dosage Reason How Long? Prescribed by Date of last checkup

_____

_____

_____

Circle ANY of the following that apply:

I have known Allergies
I have a pacemaker
I am taking Coumadin/Warfarin
I am taking Lithium (Eskalith, Lithobid, Lithonate, Lithotabs)

Please indicate the use and frequency of the following:

Coffee/Black Tea Yes/No Amount_____ Tobacco Yes/No Amount_____

Recreational Drugs Yes/No Amount_____ Alcohol Yes/No Amount_____

Water Intake Yes/No Amount_____ Soda pop Yes/No Amount_____

What are you seeking treatment for? Primary _____

Secondary _____

OB/GYN History (Women)

Age of first period (Menarche _____ Are you pregnant? Yes/No # of pregnancies _____
Age of last period (menopause)_____ # of live births _____ # Abortions _____ # of miscarriages_____
# of days between periods _____ Date of last Gynecological exam _____ Last Pap Smear date _____
# of days of flow_____ Last mammogram_____ Bone density scan_____
Color of flow _____ Results _____
Clots? Yes/No Color _____ _____
Average # of pads used per day: 1st _____ 2nd day _____ 3rd day _____ 4th day _____ + days _____
Have you been diagnosed with: ___Fibroids ___Fibrocystic breasts ___Endometriosis ___Ovarian cysts ___PID ___Other
Location of pain: ___Lower Abdomen ___Lower back ___Thighs ___Other_____
Nature of pain (Please indicate before, during or after menses)

Cramping _____ Stabbing_____
Burning_____ Aching_____
Dull_____ Bloating_____
Constant_____ Intermittent_____
Bearing down sensation

Other symptoms related to menses:

____Discharge ____Vaginal dryness ____Headache
____Nausea ____Constipation ____Diarrhea
____Swollen breasts ____Mood swings ____Big appetite
____Poor appetite ____Hot flashes ____Night sweats
Increased libido decreased libido Insomnia

Urogenital History (Men)

Date of last Prostate check up_____ PSA results_____ Manual prostate exam results_____
Lab results: _____
Frequency of urination: Daytime_____ Nighttime_____ Color of urine: ___Clear ___Murky Odor_____
Symptoms related to prostate (Please check all that apply)

___Prostate problems ___Delayed stream ___Post-void dribbling ___Incontinence ___Retention of urine
___Erectile dysfunction ___Increased libido ___Decreased libido ___Premature ejaculation ___Impotence
___Back pain ___Groin pain ___Testicular pain ___weak force of stream ___Enlarged prostate/BPH
Other

Symptom Survey

The following is a list of symptoms you may or may not ever experience. Please indicate as follows:

No mark (__) = Never experience **Plus mark (+) = Sometimes experience** **Plus mark x2 (++) = frequently experience**

____lack of appetite
____excessive appetite
____loose stools or diarrhea
____digestive issues/indigestion
____vomiting
____belching, burping
____heartburn/acid reflux
____fells like undigested food sitting in stomach
____tendency to become obsessive in work, relationships, etc…
_____
____insomnia, difficulty sleeping
____heart palpitations
____cold hands and feet
____nightmares/vivid dreams
____mentally restless
____laughing for no apparent reason
____angina pain

____abdominal pain
____chest pain
____sciatic pain
____headaches
____pain or coldness in the genital area
_____
____cough
____shortness of breath
____decreased sense of smell
____nasal problems
____skin problems
____feelings of claustrophobia
____bronchitis
____colitis or diverticulitis
____constipation
____hemorrhoids
____recent use of antibiotics

____eye problems
____jaundice (yellowish eyes or skin)
____difficulty digesting oily foods
____gall stones
____light colored stools
____soft or brittle nails
____easily angered or agitated
____difficulty in making plans or decisions
____spasms or twitching of muscles
_____
____lower back pain
____knee problems
____hearing impairment
____ringing in ears
____kidney stones
____decreased sex drive
____hair loss
____urinary problems

____fatigue
____edema
____blood in stools
____black tarry stools
____easily bruise
____difficult to stop bleeding
____asthma
____catch colds easily or often
____sensitive to weather changes
____allergies
____hay fever
____dizziness
____tendency to faint easily
____high cholesterol levels
____sudden weight loss

Anything else you think I should know _____

Notes: _____

Pain Section (If Applicable)

What do you think caused it? Is the cause still present? _____

What treatments have you tried already? What were the results? _____

Have you been given a diagnosis for this problem? If so, what? _____

To what extent does this problem interfere with your daily activities? (Work, sleep, eating, etc.)

_____

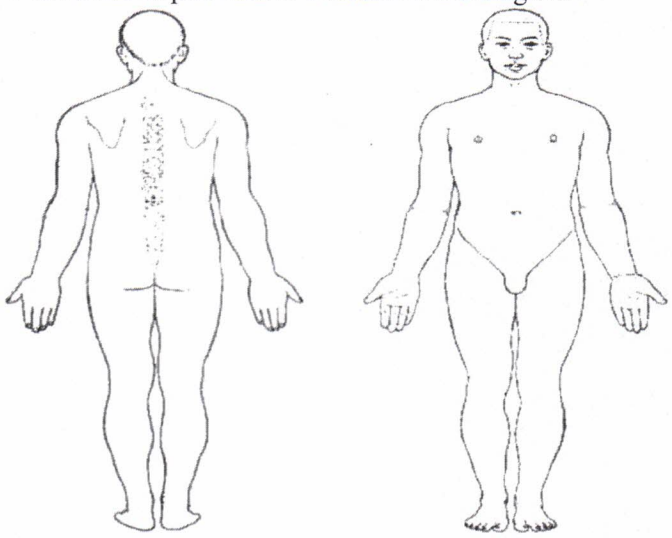
How severe is your problem right now? (Please mark the scale below)

No problem | Moderate | Worst Imaginable

What's the most severe level you have endured within the past week? (Please mark the scale below)

No problem | Moderate | Worst Imaginable

>> Mark areas of pain and/or concern on the diagram >>



What are Your Treatment Goals?

____ Temporary relief of symptoms/pain management

____ Eliminate root/cause of my health concern (If possible)

____ Maintain care (Periodic balancing/tune-up to maintain current level of health)

____ Other (Explain)

Is there anything else that you feel we should know which is relevant to your condition(s)?

_____

_____

Acupuncturist Notes: _____

_____

_____

In an attempt to improve HIPPA compliance and assist us in answering inquiries, patients need to fill out the forms below, informing us which family members are designated as having access to patient records in this office.

FAMILY CONSENT FORM

1._____ authorize _____
(Patient's name)
_____
_____
(Family member-List names if more than one)

Regarding the following:
(check all that apply)

1._____ may make appointments on my behalf.
2._____ may request Herbal refills, may ask questions about my Herbs and acupuncture treatments.
3_____ may inquire about financial matters and insurance.

I give my permission to the Staff of Misty Mountain Acupuncture to leave a message on my:

_____ Home phone _____ Cell phone _____ Work phone
_____ With above family member(s)

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Misty Mountain Acupuncture reserves the right to charge a fee of $50.00 for all missed appointments or "no shows" and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice. A missed appointment or "no show" could also result in the cancelation of future appointments.
"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment.
Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients. By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____
Printed Name Signature

Notice of Privacy Practices

I also acknowledge I was offered a written copy of Privacy Practices of Misty Mountain Acupuncture, which I

____kept ____refused. **(Check one)**

Signature: _____ Date: _____

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.

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: MATTHEW V. VACCARO

(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: MISTY MOUNTAIN ACUPUNCTURE Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE