



83 South Street, Suite 204, Freehold, NJ 07728 | (732)-780-6320 | www.RehabilityNJ.com

Acupuncture New Patient Intake

Patient Name: _____ Date: _____

Reason for visit: _____ How long have you had this condition? _____

What seemed to be the initial cause? _____ Is it getting worse? Y N

What makes it better? _____ What makes it worse? _____

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying down

Does it interfere with your: Work Sleep Daily routine Recreation

Are there other problems you would like to address? _____

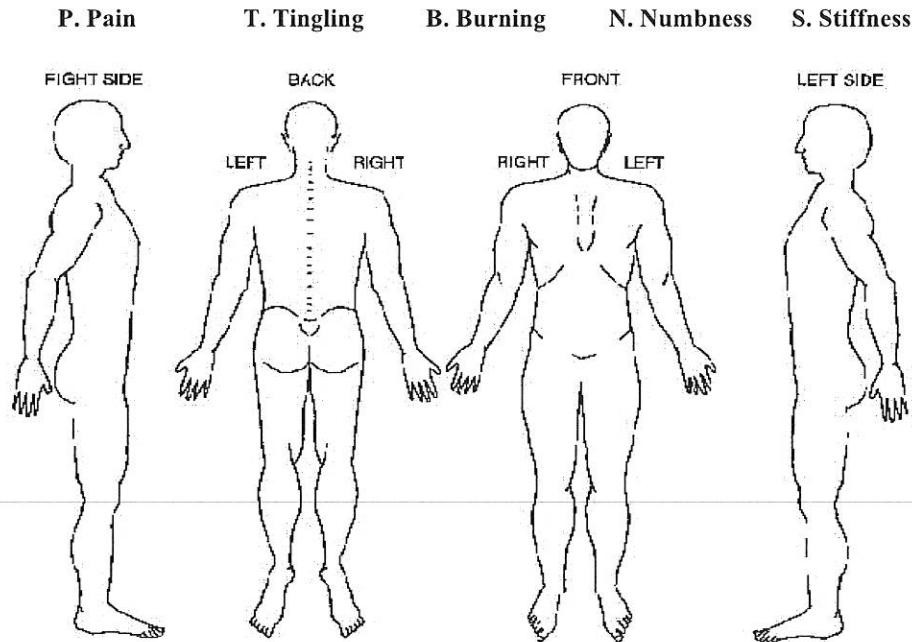
Are you pregnant? Y N Due Date: _____ Exercise: None Moderate Daily Heavy

Have you had Acupuncture before? Y N Chinese Herbal Medicine? Y N

Habits: Smoking: Packs/Day _____ Alcohol: Drinks/Week _____

Coffee/Caffeinated Drinks: Cups/Day _____ High Stress Level: Reason _____

Please complete the following diagram by using the letters below to indicate the area and type of pain you are experiencing:



Medications: _____ Allergies: _____ Vitamins/Herbs/Minerals: _____



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Please place a mark in the box to indicate if you have had any of the following:

Medical History

- Medical history checklist including: Poor appetite, Poor Sleep, Heavy appetite, Heavy Sleep, Cold hands or feet, Night Sweats, Sweat easily, Dream-disturbed sleep, Fatigue, Shortness of breath, Recent weight loss/gain, Lack of strength, Recurrent Fevers, Vertigo/dizziness, Bleed or bruise easily, Eye pain, Red eyes, Itchy eyes, Spots in eyes, Poor vision, Blurred vision, Recurrent sore throat, Grinding teeth, TMJ, Facial pain, Gum problems, Sores on lips/tongue, Dry mouth, Sinus problems, Nose bleeds, Enlarged thyroid, Ringing in ears, Earaches, Headaches, Migraines, Seasonal allergies, Asthma/wheeze, Pneumonia, Difficulty breathing while lying down, Cough: Wet or Dry?, Nausea, Vomiting, Acid regurgitation, Gas, Hiccup, Bloating, Bad breath, Diarrhea, Bowel movements: Frequency, Texture/form, Color, Odor, Constipation, Intestinal pain/cramping, Arthritis, Neck/Shoulder pain, Muscle tension, Upper back pain, Low back pain, Joint Pain, Limited range of motion, Rashes, Hives, Eczema, Psoriasis, Acne, Dandruff, Itching, Hair loss, Fungal infections, Seizures, Numbness, Tics, Poor memory, Anxiety, Depression, Irritability, Easily stressed, Abuse survivor, Seeing a therapist, Pain on urination, Frequent urination, Urgent urination, Wake to urinate, Increased libido, Decreased libido, Kidney Stone, Impotence, Irregular periods, Painful periods, PMS, Vaginal discharge, Vaginal sores, Clots, Breast lumps, Age menses began, Age at menopause, Length of cycle, Date of last period, #Pregnancies, # Live births, Date of last PAP, Other:

Family Medical History

- Family medical history checklist including: Heart Disease, Stroke, Diabetes, Cancer: Type, Other:

Do you have any blood borne illness? Hepatitis HIV AIDS Lyme disease Other:

Please list any major surgeries, traumas, or significant hospitalizations:

I certify that the information provided is current and complete to the best of my knowledge.

Patient Signature: Date:



Patient Intake

Patient Name: _____ E-Mail Address: _____

Sex: M F Date of Birth: _____ Age: _____ Marital Status: S M D W

Mailing Address: _____

Home Phone #: _____ Cell Phone #: _____

Employer/School: _____ Occupation: _____

How were you referred to our office? _____

Insurance Information

Primary Insurance Carrier: _____

Type: Medical Auto Workmans Comp Other _____

ID#: _____ Group#: _____ Claim#: _____

Subscribers Name: _____ Subscribers DOB: _____

Subscribers SS#: _____ Relationship to patient: _____

Coverage Effective Date: _____

Secondary Insurance Carrier: _____

Type: Medical Auto Workmans Comp Other _____

ID#: _____ Group#: _____ Claim#: _____

Subscribers Name: _____ Subscribers DOB: _____

Subscribers SS#: _____ Relationship to patient: _____

Coverage Effective Date: _____

In Case of Emergency

Name: _____ Relationship: _____

Home Phone #: _____ Cell Phone #: _____

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 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 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.

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

OFFICE SIGNATURE **X** _____ (Date)

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

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.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE

X

(Or Patient Representative)

(Indicate relationship if signing for patient)