ACUPUNCTURE 4 HEALTH, INC.

219 Founders Park Dr., Suite #3 Rapid City, SD 57701
31 N. First St, Custer, SD 57730

Confidential Questionnaire

Name _____ Date _____

Home Address _____ City _____

State _____ Zip _____ Home Phone _____ Work Phone _____

Email Address _____ Would you like to receive our newsletter via email? Yes__ No__ Cell Phone _____

Occupation _____ Person Responsible for your account _____

Emergency contact _____ Phone _____

Who can we thank for referring you? _____

Sex: __M __F Height: _____ Weight: _____ Birth Date _____ Age ____

Marital Status: ___ Married ___ Single ___ Divorced ___ Widowed Number of Children: _____

Previous Acupuncture? __ Yes __No When? _____ With Whom? _____

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

Illness	You	Relative	When?	Illness	You	Relative	When?
Cancer	__	__	_____	Diabetes	__	__	_____
Hepatitis	__	__	_____	Heart Disease	__	__	_____
High blood Pressure	__	__	_____	Seizures	__	__	_____
Rheumatic Fever	__	__	_____	Emotional Disorders	__	__	_____
Infectious Diseases	__	__	_____	Tuberculosis	__	__	_____
MRSA	__	__	_____				

Sexually Transmitted Diseases: __Gonorrhea __Syphilis __HIV __HPV __ Chlamydia __Herpes Date: _____

Please indicate the use and frequency of the following:

	Yes	No	Amt		Yes	No	Amt		Yes	No	Amt
Coffee/Black Tea	__	__	_____	Tobacco	__	__	_____	Water Intake	__	__	_____
Recreational Drugs	__	__	_____	Alcohol	__	__	_____	Soda Pop	__	__	_____

Please Check the Box if ANY of the following statements are true:

I have known Allergies __ Yes __ No I am taking Coumadin / Warfarin ___ Yes ___ No

I have a pacemaker __ Yes __ No I am taking Lithium (Eskalith, Lithobid, Lithonate, Lithotabs __Y __ N

List any medications and supplements you are currently taking: (continue on back if needed)

Medicine	Dosage	Reason	How Long	Prescribed by	Date last checkup

What are the main health problems for which you are seeking treatment?

_____

_____

What other forms of treatment have you sought?

_____

_____

List any other health problems you now have.

_____

_____

List any allergies, food sensitivities or food craving that you have.

_____

_____

List any accidents, surgeries or hospitalizations (include dates)

_____

_____

_____

(continue on back if needed)

Lab Results: (Please include copies)

_____

_____

_____

CLINICAL NOTES
(Practitioners Use)

HPI:

__ Onset __ Location __ Duration
__ Characteristics __ Aggr/Allev
__ Related factors __ Treatment __ Significance

How do you FEEL about the following areas of your life?

Please check the appropriate space and indicate any problems you may be experiencing

	Great	Good	Fair	Poor	Bad	Your Comments:
Significant other	__	__	__	__	__	_____
Family	__	__	__	__	__	_____
Diet	__	__	__	__	__	_____
Sex	__	__	__	__	__	_____
Self	__	__	__	__	__	_____
Work	__	__	__	__	__	_____
Exercise	__	__	__	__	__	_____
Spirituality	__	__	__	__	__	_____

FOR WOMEN

Age of 1st period (menarche) _____

Age of last period (menopause) _____

# of days between periods _____

# of days of flow _____

Color of flow _____

Clots? __ Yes __ No Color _____

Are you pregnant __Yes __ No | # of pregnancies _____

# of live births ____ | # of abortions ____ | # of Miscarriages ____

Date of last: Gynecologic exam _____ | Pap Smear _____

Mammogram _____ | Bone density exam _____

Results _____

_____

Average number of pads you use per day: 1st day ___ 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 _____

Consistent _____ Intermittent _____

Bearing down sensation _____

Other Symptoms related to menses

__ Discharge __ Vaginal dryness __ Headache

__ Nausea __ Constipation __ Diarrhea

__ Swollen Breasts __ Mood swings

__ Ravenous appetite __ Poor appetite

__ Hot flashes __ Night sweats

__ Increased libido __ Decreased libido

__ Insomnia

SYMPTOM SURVEY (FOR EVERYONE)

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

No mark () = never experienced Check mark (√) = sometimes experience Plus sign (+) = Frequently experience

__ Lack of appetite	__ Abdominal pain	__ Soft or brittle nails	__ Tendency to catch colds easily
__ Excessive appetite	__ Chest pain	__ Easily angered or agitated	__ Intolerance to weather changes
__ Loose stool or diarrhea	__ Sciatic pain	__ Difficulty in making plans or decisions	__ Allergies
__ Digestive problems	__ Headaches	__ Spasms or twitching of muscles	__ Hay fever
__ Indigestion	__ Pain or coldness in the genital area	__ Low back pain	__ Dizziness
__ Vomiting	__ Cough	__ Knee problems	__ Tendency to faint easily
__ Belching, burping	__ Shortness of breath	__ Hearing impairment	__ High cholesterol
__ Heartburn, reflux	__ Decreased sense of smell	__ Ear ringing	__ Sudden weight loss
__ Feeling the retention of food in the stomach	__ Nasal problems	__ Kidney stones	
__ Tendency to become obsessive in work, relationships,…..	__ Skin problems	__ Decreased sex drive	
__ Insomnia, difficulty sleeping	__ Feeling of claustrophobia	__ Hair loss	
__ Heart palpitations	__ Bronchitis	__ Urinary problems	
__ Cold hands and feet	__ Colitis or diverticulitis	__ Fatigue	
__ Nightmares	__ Constipation	__ Edema	
__ Mentally restless	__ Hemorrhoids	__ Blood in stool	
__ Laughing for no apparent reason	__ Recent use of antibiotics	__ Black tarry stool	
__ Angina pains	__ Eye problems	__ Easily bruised	
	__ Jaundice (yellowish eyes/skin	__ Difficult to stop bleeding	
	__ Difficulty digesting oily foods	__ Asthma	
	__ Gall stones		
	__ Light colored stool		

FOR MEN

Date of last prostate check up _____ PSA results_____ Manual Prostate exam results _____

Lab results _____

Frequency of urination: daytime _____ nighttime _____ Color or urine: ___ clear __ murky odor: _____

Symptoms related to prostate:

__ Prostate problems __ Delayed stream __ Dribbling __ Incontinence __ Retention of urine

__ Rectal dysfunction __ Increased libido __ Decreased libido __ Premature ejaculation __ Impotence

__ Back pain __ Groin pain __ Testicular pain

Other_____

_____

219 Founders Park Dr., Suite 3
Rapid City SD 57701
(605) 721-4580
info@acupuncture4health.com
www.acupuncture4health.com

New Patient Care Suggestions

Drink plenty of water before and after your appointment. Acupuncture is intended to help your body rebalance. Good hydration will assist that process.

Please avoid brushing or scraping your tongue before the appointment.

Have something to eat at least 2 hours prior to the appointment.

Wear comfortable loose-fitting clothing or bring shorts to change into.

Acupuncture can create deep relaxation. It can also bring up old pain and/or emotion. Plan to allow 10 – 15 minutes after each appointment to relax and regroup before leaving our office and continuing with your day.

Arrive a few minutes early so that you can change, use the restroom, have a drink of water, or whatever else you may need to do to prepare.

Please turn off your cell phone, pager, Ipad, palm pilot reminders, etc., during your treatment. You will get the most benefit if you are focused on yourself during this time.

Please follow the recommendations of your practitioner. She can only help you to the extent that you are willing to help yourself.

If herbs are prescribed, please follow the directions precisely. This can be challenging (some herbs taste worse than others), but persistence pays off and the benefits can be substantial.

Honesty and trust are crucial to this healing relationship. Acupuncture considers all the aspects of healing – physical, emotional, and mental. Don't overlook or censor a symptom because it seems weird or unrelated.

I have read and understand these suggestions.

Name:_____Date:_____

Or Patient's Representative: Name:_____Relationship_____

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Matters of Policy

APPOINTMENTS

Please make appointments in advance. It may take a week or two to match your availability with ours. We do try to accommodate emergencies whenever possible.

CANCELLATIONS

Due to high demand for appointments and a lengthy waiting list, we have instituted a cancellation policy to better serve our patients. If you are unable to keep your scheduled appointment, please call us as soon as possible.

MISSED APPOINTMENT CHARGES

New Patient missed appointments:	$ 175.00	48 hour notice required
Established patient missed appointment:	$ 120.00	24 hour notice required

There are extenuating circumstances. Charges may be waived at our discretion.

PAYMENT ARRANGEMENT

Payment is due at the time of your appointment. We accept personal checks, cash, debit cards, Visa or MasterCard for payments. We encourage you to call your insurance representative to see if acupuncture is covered under your policy. We can provide a Super bill and itemization for you to submit to your insurance or your flex-spending plan. VA Patients: The Veteran's Administration refers to Acupuncture 4 Health on a case-by-case basis. Contact your VA physician to request a referral.

TREATMENT PACKAGE PLAN

Cement your commitment to gentle, holistic care for you and your family by purchasing a treatment package. It's perfect for facilitating the healing of an acute condition, for making headway with a chronic condition, or for ongoing wellness care. Any member of your immediate family may use these treatments, but they must be used within 12 months from the purchase date. When you buy a treatment package, you don't have to remember your checkbook every visit and you save. A cash discount will be offered to all who pay with cash or check.

Package: $654.00 (10% savings with cash discount) OR $684.00 (5 % savings with credit/debit card)
6 treatments
Cost does NOT include herbs.

GIFT CERTIFICATES

A gift certificate is a thoughtful way to introduce a friend or family member to the gentle, effective benefits of acupuncture. Inquire at the front desk.

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medical procedures, including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed acupuncturist and or licensed acupuncturist who now or in the future treat me while employed by, working, or associated with or serving as a back-up for the treating acupuncturist named below, including those working at this office/clinic or any other office or clinic.

I understand that the methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (Chinese Massage), Chinese or Western Herbal Medicine and nutritional counseling.

I have had the opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been rare instances reported of fainting, infections and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

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 Oriental Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interest.

I understand the clinical and administrative staff may review my medical records and lab reports but all my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

To be completed by the patient

Patient's Name _____

Patient's Signature _____ Patient's Representative _____

Date Signed _____ Relationship _____

Are you pregnant Yes No

Name of Clinic/Office: **Acupuncture 4 Health, Inc.**
Name of Treating Acupuncturist(s): Kayte Halstead

ACUPUNCTURE 4 HEALTH, INC.
NOTICE OF PRIVACY PRACTICES

My signature below indicates that a written copy of the institute's Notice of Privacy Practices is available to me upon request. I have also been informed that if I require additional information about this notice I may call the Privacy office.

Patient Name:

Patient Signature:	Date:

Patient Refused to sign: _____ Staff Signature and date

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Privacy office # (605) 721-4580

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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 as provided by California 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.

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 its 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 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 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, injuctive 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 approve 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 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 the law (Civil Code 3333.1), the limitation on recover for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the National Arbitration Form 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 of notice thereof is received, the claim, if asserted in civil action, will be barred by the applicable legal statute 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 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 the 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. Please indicate relationship if signing for patient)

OFFICE SIGNATURE _____DATE_____