HEALTH HISTORY QUESTIONNAIRE

Important: *Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.*

All information is strictly confidential

I. General Patient Information

Date: ___ / ___ / _____ Name: _____

Address: _____

City, State, Postal Code: _____

Phone: Home _____ Work _____ Cell _____

May we contact you: ☐ at home ☐ at work ☐ email: _____

Age: _____ Date of Birth: ___ / ___ / _____ Place of Birth: _____

Gender: ☐ male ☐ female Height: _____ Weight: _____ lbs.

Occupation: _____ Employer: _____

Hours worked per week _____ Is your health complaint related to work? ☐ Yes ☐ No ☐ Maybe

How did you hear about our office? _____

Guardian (if under 18): _____

Person to notify in an emergency: _____ Relationship: _____

Daytime phone for above person (_ _ _) _ _ _ - _ _ _ _

Major Complaint(s), in order of significance to you:

1. _____ 4. _____
2. _____ 5. _____
3. _____ Additional: _____

How do these conditions impair your daily activities? _____

_____

_____

II. Patient Medical History

How was your childhood health? _____

Hospital Visits/Stays/Dates: _____

_____

_____

Recent tests: (please indicate test results and date below)

☐ Physical ☐ Cholesterol ☐ Prostate ☐ Blood (which?)

☐ HIV/STD ☐ Pap Smear ☐ Mammography ☐ Other: _____

Test Results and Date: _____

_____

Check any you have had in the past:

☐ Diabetes	☐ Allergies	☐ Glaucoma	☐ CVA	☐ Vein condition
☐ Thyroid disorder	☐ Tuberculosis	☐ Emphysema	☐ Jaundice	☐ Bleeding Tendency
☐ Syphilis	☐ Measles	☐ Meningitis	☐ HIV	☐ Polio
☐ High Fever	☐ Hepatitis	☐ Multiple Sclerosis	☐ Migraines	☐ High Blood Pressure
☐ Other lung illnesses	☐ Other kidney illnesses	☐ STDs	☐ Rheumatic Fever	☐ Heart Disease
☐ Asthma	☐ Pneumonia	☐ Gonorrhea	☐ Mumps	☐ Chicken Pox
☐ Nervous disorder	☐ Mononucleosis	☐ Epilepsy	☐ Paralysis	☐ Cancer
☐ Other liver illnesses	☐ Other heart illnesses	☐ Other _____		

Pets

Do you have pets? ☐ Yes ☐ No

If so, what kind and how many? _____

Is/are the pet allowed in the house? ☐ Yes ☐ No On your bed? ☐ Yes ☐ No

What kind of food do you feed your pets ? _____

Food Choices Circle each type of food you eat often.

Pre-made foods:	a) canned foods	b) boxed cereals	c) frozen dinners	d) bottled of frozen juices
	e) take-out food			
Red meat:	a) beef	b) pork	c) lamb commercially grown brand: naturally raised brand	
Chicken:	a) commercially grown brand	b) naturally raised brand:		
Turkey:	a) commercially grown brand	b) naturally raised brand:		
Fish:	a) canned tuna	b) fresh fish	c) frozen fish	d) at restaurants
Fresh vegetables:	a) commercial (in store)	b) organic (in store)	c) organic (direct from farm)	
Fresh fruit:	a) commercial (in store)	b) organic (in store)	c) organic (direct from farm)	
Whole grains:	a) commercially grown (store bought)	b) organically grown (store bought)	c) organic (direct from farmers)	
Whole beans:	a) commercially grown (store bought)	b) organically grown (store bought)	c) organic (direct from farmers)	
Eggs/Butter:	a) commercial eggs	b) organic eggs	c) commercial butter	d) organic butter
Milk:	a) commercial milk	b) organic milk	c) goat's milk	
Cheese:	a) commercial cheese	b) organic cheese (store bought)		
Other:	a) commercial ketchup	b) commercial mustard	c) vinegar	d) commercial olive oil

Food Stressors On the line please indicate how many times per week you have each item.

Stimulants

coffee (including decaf.) ____

black tea, caffeine drinks ____

soft drinks (colas, etc) ____

drinks w/NutraSweet (diet soda) ____

alcohol (wine, beer, etc) ____

chocolate ____

candy, pastries, sweets ____

Toxic Oils

fried foods ____

fast food ____

potato or corn chips ____

roasted nuts ____

mayonnaise ____

margarine ____

peanut butter ____

Commercial Dairy

cow's milk ____

yogurt ____

frozen yogurt ____

ice cream ____

sour cream ____

cheese (commercial) ____

cottage cheese ____

Highly Heated Foods

bread (store bought) ____

crackers (store bought) ____

bagels (store bought) ____

buns (store bought) ____

pasta (store bought) ____

muffins (store bought) ____

cookies (store bought) ____

Food Habits

Eating Out Do you eat out at restaurants? ☐ Yes ☐ No

If yes, how often? _____ Where? _____

What type of food do you eat at restaurants? _____

Home Meals Do you prepare meals at home? ☐ Yes ☐ No

If yes, how often? _____

If yes, what type of food do you prepare? _____

Meal Habits Do you (circle) a) skip meals often b) have irregular eating times c) eat food past 7 pm

MSG Do you avoid food/drinks that list "natural flavors" (which means hidden MSG) on the label? ☐ Yes ☐ No

Water Do you drink tap water? ☐ Yes ☐ No

What brand drinking water do you use? _____

If you have a home water purifier, when was the cartridge last changed? _____

THIS SECTION OPTIONAL

Typical Diet Please fill out your typical diet for the last few days. Please be as detailed as possible. (For example, instead of writing "chicken," identify what brand and how it was made such as "baked Foster Farms chicken." Instead of writing "salad," identify what it's made of, such as "salad made with organic baby green lettuce, commercial cherry tomatoes and PRL Olive Oil.") — PLEASE BE HONEST

Breakfast (Time eaten: _____) _____

_____

_____

_____

_____

Lunch (Time eaten: _____) _____

_____

_____

_____

_____

Dinner (Time eaten: _____) _____

_____

_____

_____

_____

Snacks (Time eaten: _____) _____

_____

Women:

Regular menstrual cycle? ☐ Yes ☐ No

Pregnant? ☐ Yes ☐ No

Number of children: _____

Number of pregnancies: _____

Age of first menstruation: _____

Age of menopause (if applicable): _____

Average number of days of flow: _____

Average number of days of entire cycle: _____

☐ Vaginal discharge ☐ Bleeding between periods ☐ Menstrual cramps: ☐ Mild ☐ Severe

Do you experience any of the following pre-menstrual syndromes?

☐ Nausea ☐ Vomiting ☐ Water retention ☐ Breast swelling

☐ Food cravings ☐ Headaches ☐ Migraines ☐ Breast tenderness

☐ Depression ☐ Irritability ☐ Anxiety ☐ Other emotions:

☐ Dull pain, where? ☐ Sharp pain where?

Women please fill in the following menstrual cycle,

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain / Cramps (location dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Men:

☐ Swollen testes ☐ Testicular pain ☐ Impotence ☐ Premature ejaculation

☐ Feeling of coldness or numbness in external genitalia ☐ Other _____

Medications: Please check the box if taking and ***list specific medications if possible***

☐ Antacids Pills ☐ Blood Thinning ☐ Aspirin ☐ Birth Control Pills

☐ Antibiotics ☐ Cortisone Pills ☐ Vitamins ☐ Weight Reduction Pills

☐ Hormones ☐ Blood Pressure ☐ Iron ☐ Cough Medicine

☐ Pain Med. ☐ Sleeping Pills ☐ Laxatives ☐ Insulin, Diabetic

☐ Water Pills ☐ Tranquilizers ☐ Digitalis ☐ Thyroid Medication

Other Medications (if you have a written list give it to the receptionist to be copied)

- _____ - _____ - _____
- _____ - _____ - _____
- _____ - _____ - _____

Other Comments: _____

Patient Signature: _____ Date: _____

PATIENT INTAKE ORGAN FUNCTION

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a possible problem with that organ's function.

Lung Function/Large Intestine Meridian/Organ Network

O Difficulty Breathing	O Smoke (# _ per day)	O Shortness of Breath	O Constipation	O Wheezing
O Loose Stools	O Sadness	O Cough	O Melancholy	O Emphysema / COPD
O Dry Skin	O Difficulty Concentrating	O Rapid, Quick Thinking	O Asthma	O Bottle Fed as child
O Excess Phlegm	O Frequent Colds/Flu	O Slow Healing Skin	O Mucus in Stool	O Other _____
O Tuberculosis	O Psoriasis	O Pulmonary Diseases	O Diarrhea	O Allergies _____
O Sweating Problems	O Sinusitis / Rhinitis	O Nasal Problems	O Chest Congestion	_____

O Sensitivities to: O Smells O Noise O Clothing O Energy O Others _____ _____

Kidney/Urinary Bladder Meridian/Organ Network

O Frequent Cavities	O Other Dental Problems	O Kidney Stones	O Easily Broken Bones	O Low Back Pain
O Memory Problems	O Excessive Hair Loss	O Frequent Night Urination	O Lack of Bladder Control	O Fear
O Easily Startled	O Fatigue / Lethargy	O Cold Hands or Feet	O Depression	O Premature Gray Hair
O Sciatica	O Decreased Will Power	O Multiple Sclerosis	O Muscular Dystrophy	O Cerebral Palsy
O Diseases of Spinal Column	O Osteoarthritis	O Infertility	O Sterility	O Cold Body Temperature
O Knee Pain	O Afternoon Flushes	O Hot Body Temperatures	O Excessive Thirst	O Night Sweats
O Heat in Chest	O Lack of Perspiration	O Perspire Easily	O Hot Flashes	O Heat in Hands or feet

O Unusual Urine Out-put (Explain) _____

Liver/Gall Bladder Meridian/Organ Network

O Anger Easily	O Frustration	O Depression	O Irritability	O Pain in the Ribs
O Tightness in Chest	O Bitter Taste in Mouth	O Tingling Sensations	O Numbness	O Gall Stones History
O Gall Stones Currently	O Seizure	O Convulsions	O Skin Rashes	O Drink Alcohol
O Headaches on side of head	O PMS Symptoms	O Fibromyaglia	O Nausea	O Tendonitis
O Liver Spots	O Substance Abuse	O Chronic Fatigue	O Parkinsons Disease	O Migratory Pain
O Brittle/Coarse Nails or Hair	O Distention/Bloating	O Flushed Face	O Muscle Spasms	O Twitching
O Cramping	O Irritable Bowel	O Sensitivity to Greasy Foods	O Migraines	O Tremors
O Menstrual Cramping	O Vertigo	O Tinnititis	O Insomnia	O Difficulty Staying Asleep
O Hiccups	O Belching	O Sour Regurgitation	O Churning Stomach	O Frequent Sighing
O TMJ	O Stiff Neck & Shoulders	O Restless Legs		

O Repetitive Strain Disorders (Please List) _____

Heart/Small Intestine Meridian/Organ Network

O Mental Confusion	O Palpitations	O Chest to Shoulder Pain	O Flushed Face	O Nightmares
O Restlessness	O Dizziness	O Vertigo	O Anxiety	O Cold Limbs
O Sores on Tip of Tongue	O Wake Unrefreshed	O Difficulty Falling Asleep	O Hearing Problems	O Pain Down the Arm
O Drink Coffee # _ Cups/Day	O Dream Disturbed Sleep	O Heart Problems	O Inflammatory Conditions	O Anemia
O Abdominal Pain	O Hot Flashes	O Hot Painful Joint	O Tongue/Speech Problems	O Disturbed Thinking
O Phobias	O Poor Circulation	O Rheumatoid Arthritis	O Spontaneous Sweating	O Lack of Joy/Humor
O Cardiac Pain	O Psychosis	O Epilepsy	O Bitter Taste in Mouth	O Shortness of Breath

O Other (Please List) _____

Spleen/Stomach Meridian/Organ Network

O Low Appetite	O Excessive Appetite	O Acid Reflex	O Heartburn	O Mouth Sores
O Abrupt Weight Gain	O Abrupt Weight Loss	O Fatigue After Eating	O Easily Bruised	O Hemorrhoids
O Over-Thinking O Worry	O Worry	O Bad Breath	O Stomach Pain	O Nausea
O Vomiting	O Abdominal Bloating	O Belching	O Passing Gas	O Hiccups
O Gurgling Noise in Stomach	O Ulcer (diagnosed)	O Burning Sensation After Eat	O Prolapsed Organs	O Aching Heavy Limbs
O Chronic Disease	O Cancer	O Diabetes	O Gastritis	O Indigestion
O Loose Stools	O Irritable Bowel	O Weak Muscles	O Headaches	O Poor Memory
O Difficulty Focusing	O Non-Breast Fed	O Fatigue	O Vein Problem	O Bitter Taste in Mouth
O Insomnia	O Excess Phlegm	O Crohn's Disease		

Pain Supplemental Worksheet

PAIN:

Location – Please describe_____

_____

On a scale from 1 to 10, how is the pain today? (1=best 10=worst) _____

Does the pain impair your ability to(please circle below):

work exercise sleep perform household tasks drive concentrate

What makes the pain worse?

sitting standing activity heat/cold massage stress lifting fatigue

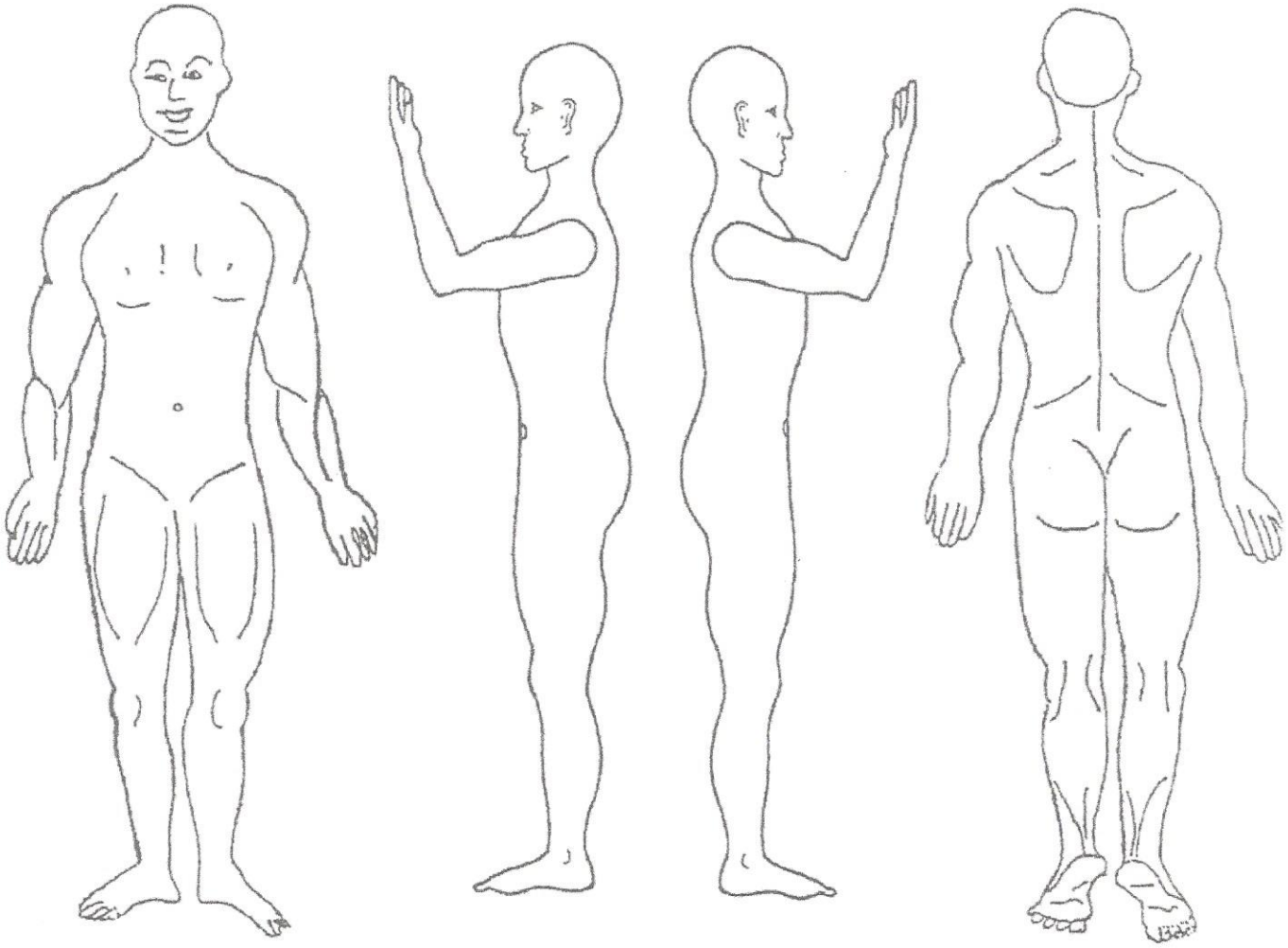
What makes the pain better?

rest activity heat/cold massage other_____

Character of Pain (circle all that apply)		Date of Initial onset_____
Dull	Distending	Cause of initial onset_____
Heavy	Superficial	What triggers the pain?_____
Sharp	Deep	_____
Ache	Throbbing	Frequency: occasional
Stabbing	Localized/Fixed	intermittent
Pulling	Changing Locations	constant

Describe pain further, in the space below, if needed.

SCAR/TRAUMA CHART



Directions

All Scars: Please draw a red line on the drawing where you have scars, even if they are very old. Don't forget C-sections, vaccination scars, episiotomies, surgeries, earring puncture holes, tattoos, facelift scars, etc.

All Trauma Areas: Please put a red "X" where you have had trauma even if it is very old. Don't forget previous sprains, burns, falls, whiplash (from auto accidents), radiation, etc.

Internal Metal: Please draw a circle on the drawing if you have any type of internal metal objects, such a surgical steel pin, metal plate, hip replacement, surgical wire mesh, etc.

Date of injury and type of injury: Draw a line from each of the above injury areas and print the type of injury and approximate date of injury. (For example, draw a line from a shoulder trauma area and print "car accident, 1988)

Notice of Patient Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.
A complete, detailed copy of HIPAA is available to read in our lobby. If you wish to take a copy for your records please ask the receptionist and they would be glad to assist you.

Authorization to use and disclose your protected health information for a special purpose

Patient's Name: _____ Date of Birth: _____

I authorize my Protected Health Information to be used or disclosed for:

Yes	No	Situation
		Health Insurance Claim Processing
		Updating my primary care physician
		Leaving test results on my answering machine
		Leaving appointment reminders on my answering machine
		Leaving billing messages on my answering machine
		Leaving messages via email. Email address:

I authorize the following people to receive my protected health information:

(Examples include another doctor besides your primary care physician, your spouse, another family member)

I understand that if my health information is disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

I understand that I may revoke this authorization at any time by giving written notice. However, I understand that my revocation is not effective to the extent that the persons I have authorized to use and or disclose my protected health information have acted in reliance on this authorization.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment, nor will it affect my eligibility for benefits. However, I understand I will be responsible to pay for my medical care in full and file claims myself if I refuse disclosure to my health insurance company.

I have had the chance to read the content of this authorization form and I agree with all statements made herein. I give this authorization voluntarily.

This authorization expires one year from date below unless revoked.

_____ _____

Signature of patient or patient's personal representative Relationship to patient

Date: _____

You Have A Right To A Copy Of This Form After You Sign It – Please Ask And One Will Be Created

Fran Ammons, Licensed Acupuncturist

Practices Regarding Disclosure of Patient Health Information

Your health information will be routinely used for treatment and insurance reporting, and your consent, or the opportunity to agree or object, is not required in these instances:

- **Treatment-** Information obtained by your practitioner by this office will be entered in your record and used to plan the course of treatment. Your health information may be shared with others involved in your care or providing consultation about treatment. Your practitioner's own expectations and those of others involved in your care may also be recorded.

- **Insurance-** You may receive a receipt from this office upon request, in order to file for insurance re-imbursement or for other record keeping. This receipt is written documentation that identifies you, your diagnosis and/or practitioner's impressions, and procedures performed.

In addition, the following disclosures are required by law and do not require your consent:

- **Food and drug Administration (FDA)-** This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.
- **Worker's Compensation-** This office will release information to the extent authorized by law in matters of worker's compensation.
- **Public Health-** This office is required by law to disclose health information to public health and/or legal authorities charged with tracking reports of birth and morbidity. This office is further required by to report communicable disease, injury, or disability.
- **Law Enforcement-**(1) Your health information will be disclosed in response to a valid subpoena for law enforcement purposes, as required under state or federal law. (2) In the event that a staff member or business associate of this office believes in good faith that one or more patients, workers, or the general public are endangered due to suspected unlawful conduct of a practitioner or violations of professional or clinical standards, provisions of federal law permit the disclosure of health information to appropriate health agencies, public health authorities, or attorneys.

It is Fran Ammons' practice to consider the following as routine uses and disclosures for which specific authorization will not be requested. You have the right to request restrictions on these uses. Otherwise, the office will request your authorization whenever disclosure of personal health information is necessary to parties other than those referenced here.

- **Communications with family** - Using best judgment, a family member, close personal friend identified by you, personal representative, or other persons responsible with your care may be notified or given information about your care to assist them in enhancing your well-being or to confirm your whereabouts.

Patient signature_____Date_____

PATIENT NAME

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 1 OF 2 - PLEASE SIGN BOTH SIDES

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.

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, and 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 or preceptorship interns who now or in the future treat 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 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 (Or Patient Representative) X (Date)

(Indicate relationship if signing for patient)

PLEASE SIGN REVERSE SIDE ALSO

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 2 OF 2 - PLEASE SIGN BOTH SIDES

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 (Oriental massage), Oriental 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. 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. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect 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 Oriental 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.

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

OFFICE SIGNATURE Date

PLEASE SIGN REVERSE SIDE ALSO

Notice of Cancellation

From: Acupuncture & Skin Rejuvenation Center

To: New Patients

Please be advised that any appointments scheduled in your behalf have been scheduled specifically for you to enjoy the gift of acupuncture/massage and have an opportunity to experience a new level of wellness.

It is very important that a **48 hour notice of cancellation/rescheduling** be given **Monday-Friday during office hours only.**
Please DO NOT leave cancellation/rescheduling notices on the answering service.
In the event a 48 hour notice is not given or you are **15** or more minutes late for your scheduled appointment, your account will be charged for the full amount of the scheduled office visit. The appointment made is **YOUR** responsibility to keep.
This office policy is very important and will be enforced.
Your appointment date can be changed once. Any/all changes after that will carry an additional $10 fee. Due to the increase in patient load, if an appointment date is cancelled/changed, there may be a delay of two or more weeks in rescheduling your appointment.
You MUST speak directly to office personnel for any and all late arrivals/ cancellation/rescheduled appointments.

Thank you for choosing the Acupuncture Clinic for your healthcare. We look forward to working with you. Be well.

Blessings,

Fran Ammons, LAc,B.S.,MSOM
and Facial Specialist

Patient Signature_____ Date_____