Sage CANCER CARE
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ACUPUNCTURE INTAKE FORM

Thank you for taking the time to complete this form. Your answers will greatly assist our doctors in providing you the best care possible. All information is confidential.

Name: ______________________________ Date of Birth: ___________ Gender: ____________

Address: ____

Email: _________________________ Preferred Contact Number: ______________________

Emergency Contact Name: ___________________________ Relationship: _______________

Emergency Contact Phone: ____

SOCIAL HISTORY

Occupation: ____________________________ Currently working (hours per week): _________

Relationship status: ☐ Single ☐ Married ☐ Long-term relationship ☐ Widowed ☐ Divorced

Have you traveled outside of the US in the past 5 years? ☐ Yes ☐ No

If yes: Where? ______________________________ When? _____________________________

Primary form of exercise, if any: _____________________________ How often: ____________

MEDICATIONS AND SUPPLEMENTS

Please list any prescriptions, OTC medications, or supplements that you currently take.

Medication/Supplement Name	Dose	Frequency

HEALTH CONCERNS

Please list, in order of importance, your health concerns followed by how long you have had each concern or conditions. Ex: High blood pressure, 5 years.

1. ____
2. ____
3. ____
4. ____

What do you believe is the cause of condition #1?

____

____

If you have been treated for this condition, what method or medicine was used?

____

____

HEALTH GOALS

Please tell me a little bit about your short- and long-term health goals.

____

____

____

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 1 to 10, with 10 being 100% committed)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you feel like you have a good support network? ☐ Yes ☐ No

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list)

____

____

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? (Please list)

____

____

Please tell us a little about what you expect from us as your wellness specialists so we can try our best to meet your needs:

____

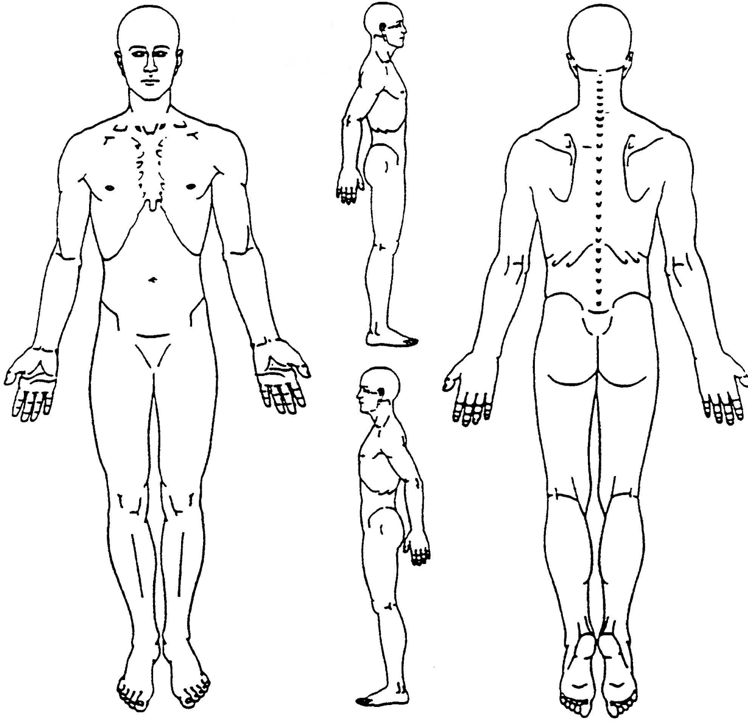
____

CURRENT SYMPTOMS

When and how did your symptoms begin: ____

____

Overall are your symptoms: ☐ Improving ☐ Remaining the same ☐ Worsening



Mark the location of your symptoms:

Pain

//// Sharp

△ Aching

↓↓↓ Radiating

*** Numbness/tingling/burning

Swelling

Pain Intensity: (rate pain from 0 to 10)

No pain Worst Pain

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

List and date any major surgeries, accidents, or traumas:

1. ________________________________ Onset? ____________ Severity? (1-10) _______
2. ________________________________ Onset? ____________ Severity? (1-10) _______
3. ________________________________ Onset? ____________ Severity? (1-10) _______
4. ________________________________ Onset? ____________ Severity? (1-10) _______

ALLERGIES

List any known allergies and describe your reaction:

1. _______________________________ 4. _______________________________
2. _______________________________ 5. _______________________________
3. _______________________________ 6. _______________________________

REVIEW OF SYSTEMS

Please check any conditions you are currently experiencing or have experienced in the past.

Gastrointestinal

- ☐ Nausea
- ☐ Pain/Cramps
- ☐ Excess Gas
- ☐ Vomiting
- ☐ Excess belching
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Black stools
- ☐ Sensitive abdomen
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Blood in stools
- ☐ Bad breath
- ☐ Peptic ulcers
- ☐ Rectal bleeding
- ☐ Gastritis

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Blood clots
- ☐ Dizziness
- ☐ Fainting
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Cold hands/feet
- ☐ Difficulty breathing
- ☐ Irregular heartbeat
- ☐ Hand/foot swelling

Respiratory

- ☐ Cough
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Asthma
- ☐ Bronchitis
- ☐ Tightness in chest
- ☐ Phlegm production
- ☐ Breathing difficulties when lying down

Genito-Urinary

- ☐ Pain on urination
- ☐ Incontinence
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Impotency
- ☐ Blood in urine
- ☐ Waking to urinate

*If waking to urinate at night, how many times per night (on average)? ________

Neuropsychological

- ☐ Seizures
- ☐ Depression
- ☐ Area of numbness
- ☐ Anxiety
- ☐ Poor memory
- ☐ Mood swings
- ☐ Concussion
- ☐ Easily stressed

*Have you been treated for emotional difficulties? ☐ Yes ☐ No If so, when? ___________________

Head, Eyes, Ears, Nose, Throat

- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Dry mouth
- ☐ Dry throat
- ☐ Excess saliva
- ☐ Gum problems
- ☐ Frequent sore throat
- ☐ Lip/Tongue Sores
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Excess mucus
- ☐ Migraines
- ☐ Facial pain
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Blurry vision
- ☐ Cataracts
- ☐ Spots in eyes
- ☐ Eye strain
- ☐ Night blindness
- ☐ Glasses/Contacts
- ☐ Eye pain
- ☐ Poor vision
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Eye strains

Skin and Hair

- ☐ Rashes
- ☐ Eczema
- ☐ Ulcerations
- ☐ Acne
- ☐ Hives
- ☐ Dandruff
- ☐ Itching
- ☐ Loss of hair

*Change in hair/skin texture? ☐ Yes ☐ No

*Other hair/skin problems: ____

REVIEW OF SYSTEMS - CONTINUED

Sweat

☐ Easily perspire ☐ Rarely perspire ☐ Night sweats

Temperature

☐ Heat intolerance ☐ Cold intolerance ☐ Alternating hot/cold

*If you experience feelings of heat, where is it located? ____________________

*If you experience feelings of coldness, where is it located? __________________

Sleep

☐ Cannot fall asleep ☐ Wake too early ☐ Tossing/turning ☐ Tired upon waking
☐ Wake up easily ☐ Excessive sleep ☐ Snoring ☐ Lots of dreams

*How many times do you wake up during the night (on average)? _____

Appetite

☐ Large ☐ Average ☐ None ☐ Snacks between meals

Please fill this out according to your current lifestyle:

	NONE	A LITTLE	A LOT
Fruits and veggies			
Meat			
Dairy			
Fast food			
Soda/Caffeine			
Sugar			
Gluten			
Cigarettes			
Alcohol			
Marijuana			
Other recreational drugs			

Pregnancy and Gynecology (if applicable)

Are you pregnant? ☐ Yes ☐ No If Yes, how many months? ___________________________________
Number of children: _____ Ages: ____
Number of pregnancies: ____ Number of live births: ____ Premature births: ____ Miscarriages: _____
Last PAP: _____ Age at first period: ____ Period duration (days): ____ Last period: ____
Flow: ☐ Heavy ☐ Light ☐ Regular ☐ Irregular
Menopausal Status: ☐ Pre-menopausal ☐ Post-menopausal
Do you experience clotting and/or vaginal discharge? ☐ Yes ☐ No
If yes, how much and how often? ____
Do you experience vaginal sores? ☐ Yes ☐ No Breast lumps? ☐ Yes ☐ No

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, Tiu-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. 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 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: ______________________________________

Patient Name: ____

Patient Signature: ____ Date: _____________

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including 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, 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 Name: ____

Patient Signature: ____ Date: _____________

Office Signature: ____ Date: _____________