Contact Information

(If Client is under 18, this form should be completed by parent or guardian)

First Name:_____ Last Name:_____ Date of Birth:_____

Email Address:_____ Home Phone Number: _____

Cell Phone Number: _____ Cell Phone Provider:_____

Work Phone:_____ Occupation: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Preferred Method of contact (Please Circle One): Phone Call Email Text Message

How Did You Find Us?

(If Client is under 18, this form should be completed by parent or guardian)

CHECK THE BOX THAT INDICATES HOW YOU HEARD ABOUT US

- ❑ Friend or Family Member:(Name)_____
  - ❑ If "friend or family member," did they buy you a gift certificate? **YES NO**
- ❑ Medical Professional:(Name and Title) _____
- ❑ Advertising: Television Radio Outdoor ad Y. Pages Other:_____
- ❑ Internet: our website Facebook Instagram Twitter Yelp
  Google search Google Reviews Other:_____
- ❑ Community Event: (specify where you saw us)_____
- ❑ Other: (Please specify)_____
- ❑ I am a returning customer: (what kept you away?) _____

Acute Pain Relief Client Information

(If Client is under 18, this form should be completed by parent or guardian)

PERSONAL DATA

First Name:_____Middle Initial:_____Last Name:_____ Birth Date:_____

Occupation:_____Employer:_____

Family Doctor:_____Permission to Consult with Physician? Initial if Yes:_____

Date of Last Dr Visit:_____ Height:_____ Weight: _____

Emergency Contact:_____ Relationship:_____ Phone#:_____

List Recent Surgeries:_____ Recent Illnesses:_____

Current Medications: _____

Current Exercise or Relaxation Activities: _____

TELL US ABOUT YOUR PAIN

Rate your pain as of today on a scale from 1-10 (with 10 being the worst pain you've ever felt): _____

Is the Pain Constant?: **YES** **NO**

What makes the pain worse (eg: Sitting/walking/heat/cold/etc):_____

What helps the pain?:_____ How long have you had it?: _____

Was there a sudden onset? **YES** **NO** If "Yes," what started the pain?: _____

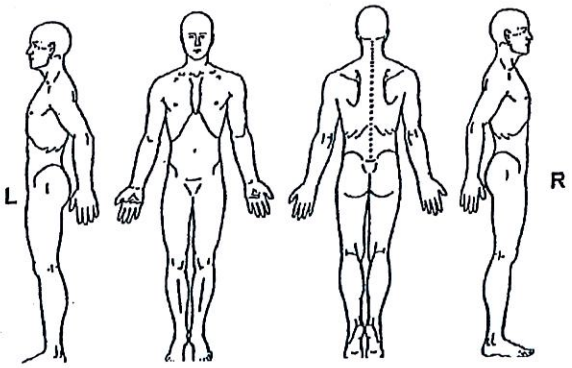
What does it feel like?: **DULL ACHY SHARP STABBING FIXED THROBBING HOT COLD OTHER**

Are you experiencing any swelling?: **YES NO** If "Yes," where?: _____

Any change in color or temperature at the site of injury?: **YES NO**

If "Yes," please describe:_____

Please indicate on the model below the area(s) of pain with a circle, & area(s) of numbness/tingling with an "X"



Client Health History

(If Client is <18 years old, this form must be completed by parent or guardian)

Please indicate all that apply and explain below:

	MUSCULO-SKELETAL
	Bone or Joint Disease
	Tendonits
	Arthritis
	Low Back/Hip/Leg Pain
	Neck/Shoulder/Arm Pain
	Headaches/Head Injuries
	Spasms/Cramps
	Jaw Pain/TMJ
	Lupus
	Broken Bones
	Specify:
	Sprains/Strains
	Specify:
	Other/Elaborate:

	CURCULATORY
	Heart Condition
	Varicose Veins
	Blood Clots
	High Blood Pressure
	Low Blood Pressure
	Lymph Edema
	Breathing Difficulty
	Sinus Problems
	Allergies
	Specify:
	Other/Elaborate:

	NERVOUS SYSTEM
	Herpes/Shingles
	Numbness/Tingling
	Chronic Pain
	Chronic Fatigue Syndrome
	Sleep Disorders
	Other/Elaborate:

	INFECTIOUS DISEASE
	Specify:

	REPRODUCTIVE
	Women:
	Pregnant (Trimester):
	PMS
	Men/Women:
	Other/Elaborate:

	SKIN
	Allergies
	Specify:
	Rashes
	Warts
	Other/Elaboarate:

	DIGESTIVE
	Constipation
	Gas/Bloating
	Diverticulitis
	Irritable Bowel Syndrome
	Other/Elaborate:

	OTHER
	Cancer
	Diabetes
	Eating Disorders
	Depression
	Drug/Alcohol Use
	Nicotine/Caffeine Use
	Other/Elaborate:

PLEASE CIRCLE THE AREAS OF THE BODY YOU GIVE PERMISSION TO BE MASSAGED:

BACK	**HIPS**	**UPPER CHEST**	**FACE**
UPPER LEGS	**GLUTES/BUTTOCKS**	**NECK**	**FEET/HANDS**
LOWER LEGS	**ABDOMEN**	**HEAD**	**ARMS**

Client Signature: _____ **Date:**_____

(Parent or guardian signature required if Client is under 18 Years of age)

Printed Name:_____ **Relationship to Client:** _____

(if signee is not client)

Patient Information and Consent Form

(If Client is under 18, this form must be completed by parent or guardian)

Please read carefully, and ask your practitioner if there is anything that you do not understand.

While Acupuncture, Chinese Medicine and other treatments provided by this clinic have proven to be highly effective in correcting conditions and maintaining overall well-being, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply in your case, your practitioner will discuss these with you. ALL MEDICAL PROCEDURES HAVE RISKS AND BENEFITS, AND BY SIGNING THIS FORM YOUR ARE ACKNOWLEDGING THESE RISKS.

WHAT ARE THE POSSIBLE SIDE EFFECTS OF ACUPUNCTURE?

- Drowsiness can occur in a small number of patients, and if affected, you are advised not to drive; this will last for only a short time.
- Minor bleeding or bruising can occur at the acupuncture site
- In less than 3% of patients, symptoms may become worse before they improve for 1-2 days following the treatment. This is usually a good sign. Please advise your acupuncturist if worsening of symptoms continues for more than the 2 days.

WHAT ARE THE POSSIBLE SIDE EFFECTS OF CHINESE MEDICINE AND OTHER TREATMENTS PROVIDED AT THIS CLINIC?

- Bruising is a common side effect of cupping or gue sha.
- The herbs and nutritional supplements from plant, animal and mineral sources that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be unsafe in large doses or inappropriate during pregnancy. As a precaution, always take herbs and supplements at the instructed dosages, and please inform your practitioner if you're are or plan on becoming pregnant in the near future. All herbs dispensed are GMP certified.

IS THERE ANYTHING YOUR PRACTITIONER NEEDS TO KNOW?

- Apart from the usual medical details, it is imperative that you let your practitioner know.
- If you have ever experienced a fit, faint, or other odd sensations
- If you have a pacemaker or any other electrical implants
- If you are pregnant
- If you have a bleeding disorder, or if you are taking anticoagulants (blood thinners) or any other medications
- If you have damaged heart valves or have any particular risk of infection

STATEMENT OF CONSENT

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I CAN REFUSE TREATMENT AT ANY TIME, AND HAVE TO QUESTION ACTIONS. I wish to rely on my practitioner to exercise judgment during the course of treatment which, is based upon the facts then known, is in my best interests. I understand the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my consent.

By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

PRIVACY POLICY

The information received and collected about our clients/patients from their visit to Creative Wellness Acupuncture is strictly private and confidential. It is used and viewed only by the healthcare professional and staff employed at Creative Wellness, UNLESS, in the best interest of the client/patient. A practitioner determines that there is need to communicate with another person or healthcare practitioner outside of Creative Wellness. ALSO Creative Wellness will not give, share, sell, or transfer any personal information to a third party unless required by law. Under absolutely no circumstances will this communication happen without the sign consent of the client/patient. Please notify us if you would like a copy of our Privacy Policy.

Client Signature: _____ **Date:**_____

(Parent or guardian signature required if Client is under 18 Years of age)

Printed Name:_____ **Relationship to Client:** _____

(if signee is not client)

Acupuncture Arbitration Agreement

(If Client is under 18, this form should be completed by parent or guardian)

Patient Name: _____

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 or 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 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 intended to bind the patient and the healthcare 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 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.

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, were applicable, establishing the right to introduce evidence to 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 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 if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If the patient intends this agreement to cover services rendered before the date if 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 me 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 OR THIS CONTRACT.

Patient Signature: _____ **Date**_____ **Relationship:**_____

(Or Patient Representative if Patient is under 18 or unable to sign)

Office Signature:_____ **Date**_____

ALSO **SIGN THE INFORMED CONSENT** ON **REVERSE** SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

(If Client is under 18, this form should be completed by parent or guardian)

Acupuncturist Name: _____

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 name 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, 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. 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 risk 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.

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 on 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.

Client Signature: _____ **Date:**_____

(Parent or guardian signature required if Client is under 18 Years of age)

Printed Name:_____ **Relationship to Client:** _____

(if signee is not client)

ALSO **SIGN** THE **ARBITRATION AGREEMENT** ON **REVERSE** SIDE

Client/Patient Agreement

(If Client is under 18, this form must be completed by parent or guardian)

Please Initial Each Section and Sign Below

It is my choice to receive therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasms or pain, or for increasing circulation or every flow. I agree to communicate with my practitioner any time I would like a modification to the procedure being used. **Initials:** _____

I understand that practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. **Initials:** _____

I have stated all medical conditions of which I am aware, and will update the massage practitioner of any changes to my health status. **Initials:** _____

I agree that I will inform my provider of any special needs or treatment requests at the time that treatment is provided. I agree other employees of Creative Wellness, such as reception staff, do not have the medical expertise to ensure that my requests can or will be honored, and that the best outcomes will result from an open dialogue with my provider at that time of treatment. **Initials:** _____

I was able to review the Creative Wellness, Inc. Notice of Privacy Practices at Creative Wellness. The Notice of Privacy Practices was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices. I know that I can ask for a copy of the Notice of Privacy Practices to take with me. I was able to view the Notice of Privacy Practices on the first day I received health care services after April 14, 2003. If I came in for heath care services in an emergency treatment situation, I was able to view the Notice as soon as reasonably practicable after the emergency treatment situation.
Initials: _____

I agree to be financially responsible for all charges incurred at Creative Wellness including, if applicable, any deductible, co-payment, and any services rejected by my insurance company. I understand that Creative Wellness is not responsible for any incorrect information provided by my insurance company regarding coverage and care. **Initials:** _____

As a courtesy to Creative Wellness therapists, I understand that I am expected to give 24-hours' notice of a cancellation. If I give less than 24-hours' notice, I understand that there will be a $25 cancellation fee, and my appointment will be charged in-full after 3 late cancellations. For parties of 3 or more, I will be required to give credit card numbers prior to booking and any cancellations under 24-hours notice will be charged in-full. **Initials:** _____

Client Signature: _____ **Date:** _____

(Parent or guardian signature required if Client is under 18 Years of age)

Printed Name: _____ **Relationship to Client:** _____

(if signee is not client)