Julie Senko, M.S., ATC., LAc, CSCS

Date _____

EVALUATION FORM

Please fill this form out as completely as possible. The information you give helps me to understand your condition more fully. All information provided is confidential. Please print clearly.

Name _____ Age _____

What do you want treated with acupuncture _____

How long have you had this condition? _____ Onset was Sudden/Gradual

Symptoms relieved by: _____

Symptoms worsened by: _____

What medical diagnosis have you received? _____

Other treatments you received recently _____

_____

What medications are you taking and for what condition:

_____ _____

_____ _____

_____ _____

Are you pregnant? _____ Trying to conceive? _____

Medical History

Dates and major injuries, illness, or surgery

_____ _____

_____ _____

_____ _____

Please circle any existing conditions:

Alcoholism	Hepatitis A/B/C	Polio
Allergies	Herpes	Rheumatic fever
Asthma	HIV/AIDS	Scarlet fever
Birth trauma	Latex Allergy	Seizures
Cancer	Lyme disease	Tuberculosis
Diabetes	Lymph node removal	Other:
Emphysema	MS	_____
Heart disease	Pacemaker	_____

Phone numbers

Day _____

Eve _____

Address _____

_____

Date of Birth _____

Occupation _____

Referred by _____

_____

Emergency Contact

_____

Phone _____

Physician _____

Phone _____

Insurance _____

ID # _____

Physician referral is required for acupuncture services in Pennsylvania. Please ask your physician for a prescription for evaluation and treatment with acupuncture. - Include ICD-9 codes. (See page 5 for further detail regarding this requirement.)

_____

Signature

_____

Date

Family Medical History

Father _____

Grandparents _____

Mother _____

_____

Siblings _____

CARDIOVASCULAR/NEUROLOGICAL

Blood pressure ____/____

Have you been diagnosed with a heart condition?

_____

_____

Do you have or have had often: (circle)

Chest pain	Poor circulation
Palpitations	Cold Hands/Feet
Arrhythmia	Numbness/Tingling
Varicose veins	Burning sensations

EMOTIONS & SLEEP

How do you feel emotionally? _____

Where do you hold stress? _____

How do you relax? _____

How do you feel about your:

Work: _____

Relationships _____

Do you use?

Non-prescription drugs Antidepressants

Recreational drugs

Do you experience:

Panic attacks	Depression
Poor memory	Difficult concentration
Bad temper	

How long do you sleep per night? _____

Do you have problems with?:

Falling asleep	Waking at _____ because
Staying asleep	Disturbed sleep

URINARY & GENITAL

Urination: How often? ___/day
Color: Pale yellow/ Dark yellow/ Orange
Do you have or have had often?

Frequent urination	Trouble holding urine
Incontinence	Trouble starting urine
Pain urinating	Urinary Tract infections
Burning sensation	Blood in Urine
Painful intercourse	Infertility

How is your sexual energy? _____

What kind of birth control do you use?

_____

Men

Do you have or have had often (circle):

Prostatitis Impotence

Women

At what age did you begin menstruation? _____
Cycle _____ days
Menses _____ days
Color _____

PMS Symptoms _____

_____

Menopausal symptoms _____

_____

Do you have or have had often (circle)

Irregular menses	Pain around menses
Heavy/ Light flow	No menses
Clots	Discharge from breasts
Vaginal discharge	

Number of deliveries ___ Miscarriages/Abortions __

DIET

How is your appetite _____

Any food cravings _____

Any food intolerance _____

Vitamins/minerals you take: _____

_____

Are you thirsty? _____

Do you prefer: hot / cold drink

How often do you have: Coffee/Tea _____day/week

Sugar/Sweets _____day/week Alcohol ____day/wk

Rate your preference: (1-lowest 5-highest)

Sour ___ Bitter ___ Sweet ___ Spicy ___ Salty___

Typical Meals:

Breakfast _____

Lunch _____

Dinner _____

GASTROINTESTINAL

Bowel movements: Painful? ___ How often? ____ day/week

Do you often have or have had often (circle)

Abdominal pain	Diarrhea	Undigested food in stool	Hemorrhoids
Hypochondriac pain	Loose stools	Blood in stools	Hernia
Nausea/Vomiting	Hard stools	Heartburn	Indigestion
Constipation	Belching	Acid reflux	Gas
Use laxatives	Other: _____		

EXERCISE & ENERGY

How is your energy level? _____

When is your energy highest? _____

Do you fatigue easily? _____

What kind of exercise do you do? _____

Lowest? _____

How often do you exercise? _____

RESPIRATORY/ENT

Do you have or have had often? (circle)

Frequent colds	Asthma	Painful/red eyes	Ringing in the ears
Chronic runny nose	Pain inhaling	Poor/blurred vision	Poor hearing
Chronic cough	Shortness of breath	Dizziness/Vertigo	Bleeding gums
Cough with blood	Nose bleeds	Ear pain	Cough with mucus

SKIN & HAIR

Do you often have or have often had

Dry Skin	Skin Rashes	Eczema	Itching	Premature Graying
Edema	Acne	Hives	Hair Loss	_____

MUSCLE, JOINTS & BONES

Where is your pain _____

The pain is:

Sharp	Numb	Dull
Achy	Burning	Deep

_____

Better / Worse with Touch

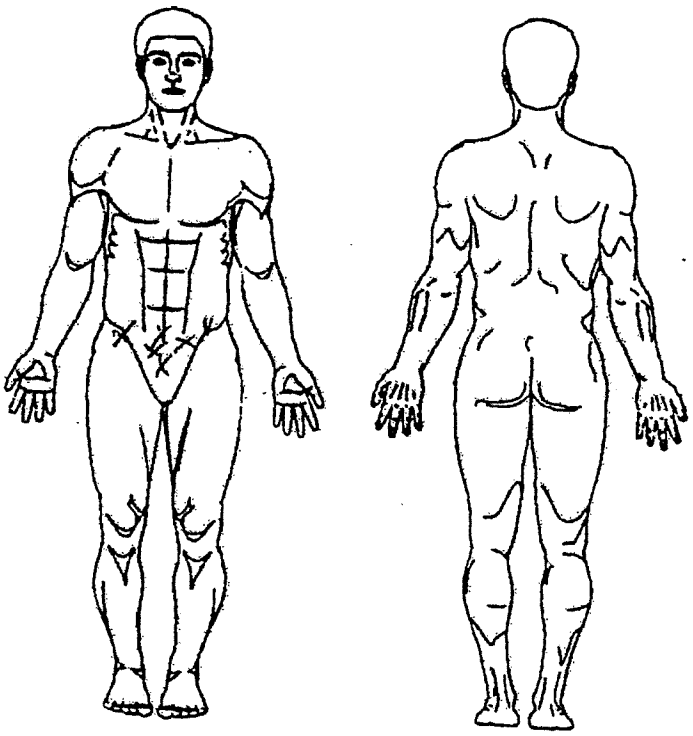
Better / Worse with Heat

Better / Worse with Cold

I have:

Swollen Joints	Muscle Cramps/Pain
Arthritis	Bone Pain
Tendonitis	Repetitive Strain
Rheumatism	_____

* Shade the areas that you would like to hale addressed



Thank You

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, 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 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 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.

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.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

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.

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

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