Asheville Clinic:
251 Haywood St Suite D Asheville NC 28801

Brevard Clinic:
235 Rosman Hwy Brevard NC 28712

GENERAL CLIENT INFORMATION

Last Name _____ First Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Address _____
(street) (city) (state) (zip)

Date of Birth _____ Occupation _____

Marital Status _____ Age _____

Name of Emergency Contact Person _____

Phone Number for Emergency Contact Person _____

Your Primary Care Physician _____

Are you or your spouse a veteran? ☐ Yes ☐ No

Are you afraid of needles? ☐ Yes ☐ No

Who can we thank for referring you? _____

FOR OFFICE USE ONLY

ICD-10 CODE(S): _____ DATE OF FIRST TREATMENT: _____

Health Concerns

MAIN CONCERN: _____

How does this problem affect your daily activities? _____

_____

_____

_____

When did you first notice symptoms? _____

_____

What kinds of treatment or therapies have you tried? _____

_____

_____

Present Health Concerns

Please list most important health concerns in order of significance	Prior diagnosis of this problem? If so, what?
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

HOSPITALIZATIONS/SURGERIES/ACCIDENTS: _____

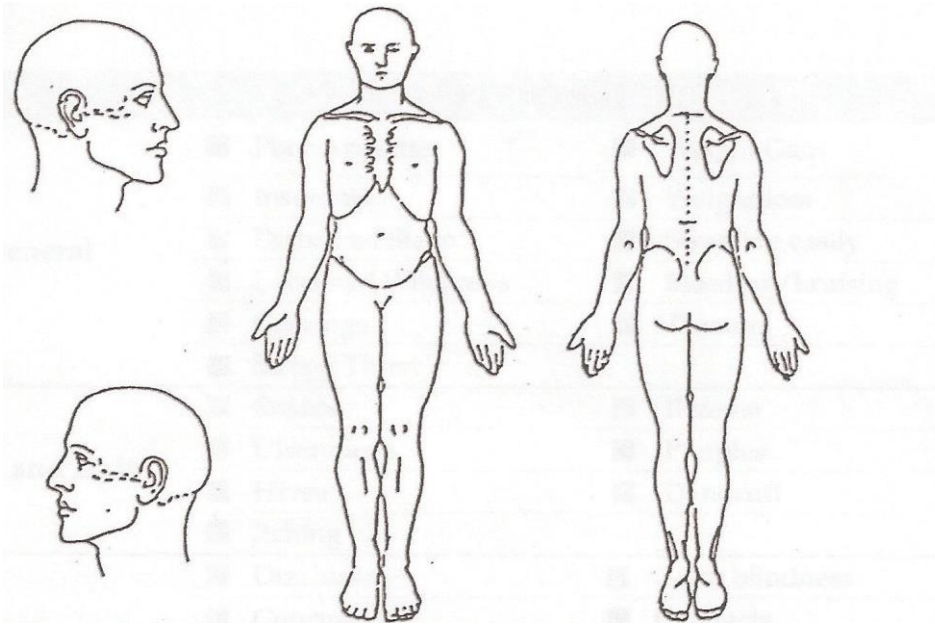
_____

_____

ALLERGIES: _____

_____

PLEASE MARK PAINFUL OR DISTRESSED AREAS ON THE CHARTS BELOW



Symbol	Reaction
PAIN	
X	little
XX	moderate
XXX	strong
SWELLING	
^	slight
^^	moderate
^^^	severe
PULSING	
O	slight
OO	moderate
OOO	strong
WEAKNESS/TEMP.	
~	weak
+	hot
SKIN PROBLEMS	
*	skin issue

Exercise

- ☐ Sedentary (No exercise)
- ☐ Mild exercise (e.g. climb stairs, walk 3 blocks, golf)
- ☐ Occasional vigorous exercise (workout/recreation less than 4x/week for 30 min.)
- ☐ Regular vigorous exercise (workout/recreation 4x/week for 30 min.)

Please list drugs, herbs and supplements you currently take:

Current Physical Symptoms

General

- ☐ Poor appetite
- ☐ Insomnia
- ☐ Disturbed sleep
- ☐ Localized weakness
- ☐ Cravings
- ☐ Strong thirst
- ☐ Weight gain
- ☐ Weight loss
- ☐ Sweating easily
- ☐ Bleeding/bruising
- ☐ Tremors
- ☐ Night sweats
- ☐ Fever
- ☐ Chills
- ☐ Sudden energy drop
- ☐ Poor Balance

Skin & Hair

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Recent moles
- ☐ Changes in hair texture
- ☐ Hair loss

Head, Eyes, Ears, Nose, Throat

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glasses
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night blindness
- ☐ Photophobia
- ☐ Color blindness
- ☐ Cataracts
- ☐ Blurry vision
- ☐ Earaches
- ☐ Ringing in the ears
- ☐ Poor hearing
- ☐ Eye strain
- ☐ Sinus problems
- ☐ TMJ
- ☐ Recurrent sore throats
- ☐ Nose bleeds
- ☐ Grinding teeth
- ☐ Sores on lips or tongue
- ☐ Facial pain
- ☐ Teeth problems
- ☐ Headaches
- ☐ Jaw clicks
- ☐ Gum/teeth problems

Cardio-vascular

- ☐ Dizziness
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Tightening in chest
- ☐ High blood pressure
- ☐ Fainting
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Palpitations
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Difficulty in breathing
- ☐ Phlebitis
- ☐ Stroke

Respiratory

- ☐ Cough
- ☐ Asthma
- ☐ Bronchitis
- ☐ Shortness of breath
- ☐ Frequent colds or flu
- ☐ Excessive phlegm

Gastro-intestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas/bloating
- ☐ Parasites
- ☐ Belching
- ☐ Black stools
- ☐ Blood in stools
- ☐ Indigestion
- ☐ Bad breath
- ☐ Diverticulitis
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Abdominal pain/cramps
- ☐ Chronic laxative use
- ☐ Chron's
- ☐ Colitis

Current Physical Symptoms (cont.)

Genito-urinary	☐ Pain on urination	☐ Incontinence	☐ Sores on genitals
	☐ Low to no sex drive	☐ Decrease in flow	☐ Impotence/frigidity
	☐ Blood in urine	☐ Kidney stones	
Musculo-skeletal	☐ Neck pain	☐ Back pain	☐ Hand/wrist pain
	☐ Muscle pain	☐ Muscle weakness	☐ Shoulder pain
	☐ Knee pain	☐ Foot/ankle pain	☐ Hip pain
	☐ Sciatica	☐ Tinnitus	☐ Arthritis
	☐ Migraines	☐ Varicose veins	
Neuro-psychological	☐ Seizures	☐ Poor memory	☐ Anxiety
	☐ Dizziness	☐ Depression	☐ Bad temper
	☐ Loss of balance	☐ Concussion	☐ Frequent mood swings
Other Illness	☐ HIV positive	☐ Rheumatic fever	☐ Eating disorder
	☐ AIDS	☐ Hypoglycemia	☐ Jaundice
	☐ Epstein-Barr	☐ Diabetes	☐ Hepatitis
	☐ Mononucleosis	☐ Underweight	☐ Overweight

Diet	Are you dieting?	☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?	☐ Yes	☐ No
	Number of meals you eat in an average day:		
	Describe daily diet:		
Caffeine	Indicate # of cups/cans per day ☐ Coffee_____ ☐ Tea_____ ☐ Cola _____		
Tobacco	☐ Tobacco_____packs per day Type?_____ # ofyears _____		
Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If so, how many drinks per week?		
Mental Health	Is stress a major problem for you?	☐ Yes	☐ No
	Do you feel depressed?	☐ Yes	☐ No
	Do you panic when stressed?	☐ Yes	☐ No
	Do you have problems with eating or your appetite?	☐ Yes	☐ No
	Do you cry frequently?	☐ Yes	☐ No
	Have you ever attempted suicide?	☐ Yes	☐ No
	Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
	Do you have trouble sleeping?	☐ Yes	☐ No
	Have you ever been to a counselor?	☐ Yes	☐ No

For Women Only

Age at onset of menstruation: _____ Date of last period: _____

Period occurs every _____ days

Number of pregnancies _____ Number of live births _____

Heavy periods, irregularity, spotting, pain or discharge?	☐ Yes	☐ No
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder or kidney infections within the last year?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around the time of your period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps or nipple discharge?	☐ Yes	☐ No

For Men Only

Do you usually get up to urinate during the night?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder or prostate infections within the last year?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No

Please list in chronological Order all surgeries, traumas, and major life events from the day you were born. Use extra pages.

Phone Number: 828 484 1050 Email: Sarah@FlowerMountain.org

Although symptoms are healing effects, we don't anticipate that you should experience any healing events, in case you do please call me to let me discuss this with you at that time.

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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

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.

(Date)

PATIENT SIGNATURE **X**

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

(Date)

OFFICE SIGNATURE **X**

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ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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 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, 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 have 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 appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

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, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). 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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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 NAME:

ACUPUNCTURIST NAME: Chris Jacobs Sarah Fields & Dov Shoneman

(Date)

PATIENT SIGNATURE **X**

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE