Hope Acupuncture
Rora Park
M.A.T.C.M., Dip!.Ac, L.Ac.

Patient Information

Contact Information

Today's Date:

First and Last Name: Middle Initial: Birth Date:

Address: City: State: ZIP:

Primary Phone: Work Phone: Email Address: Social Security Number:

Is this *visit* due to an injury? Height:
0 Work O Motor Vehicle Accident O Other:
Name of Physician: Physician's Phone: Weight:

Name of Emergency Contact: Relationship: Contact's Phone: Gender:

How Did You Hear About Us? Marital Status:

If You Were Referred, By Whom?

Employment Status

Approximate Hours You Work Per Week:

0 FullTime 0 Part Time 0 Retired 0 Unemployed 0 Student

Occupation:

Employer Name:

Insurance Information

Name of Insurance Company:

Policy Name (if applicable):

Policy Number: Group Number:

Policy Holder's Name:

Policy Holder's Employer (if applicable):

Insurance Company Telephone: Insurance Company Fax:

Insurance Company Address:

For Office Use Only
Name of Insurance Representative: Policy Start Date:
Policy Deductible: Policy Co-pay An;ount: Number of Visits Covered:
Date Deductible Met: Office Visit Covered:

You and Your Family's History

Please indicate *whether* you or a *blood* relative *have had* any *of the* conditions listed.

Self	Relative	Condition	Self	Relative	Condition
0	0	AIDS/HIV	0	0	Kidney Disease
0	0	Alcoholism	0	0	Leukemia
0	0	Allergies	0	0	Mental Illness
0	0	Anemia	0	0	Macular Degeneration
0	0	Arthritis/Rheumatism	0	0	Migraine/Headache
0	0	Asthma	0	0	Mononucleosis
0	0	Auto Immune Disease	0	0	Nervous Breakdown
		What Types?	0	0	Obesity
0	0	Bleeding Tendency	0	0	Osteoporosis
0	0	Cancer	0	0	Rheumatic Fever
0	0	Colitis	0	0	Seizures
0	0	Congenital Heart Disease	0	0	Sexually Transmitted Diseases
0	0	Diabetes	0	0	Stroke
0	0	Goiter	0	0	Suicide
0	0	Heart Disease	0	0	Thyroid Disease
0	0	Hepatitis	0	0	Tuberculosis
0	0	Herpes	0	0	Ulcers
0	0	High Blood Pressure/Hypertension	0	0	Other:

Your Health History

General Symptoms

Please indicate *whether* you are currently experiencing *the symptoms* listed, or if you *have experienced the symptoms* in *the past.*

General Health

- 0 Do You Often Catch Colds and Other Illnesses?
- 0 Do You Often Have Headaches?
- 0 Other:

Energy

- 0 Feel Tired or Weak, Lack Energy
- 0 Sudden Energy Drop
  Time: am/pm
- 0 Post-Meal Energy Drop

Thirst

- 0 Frequently Thirsty
- 0 Almost Never Thirsty
- 0 Dry Mouth
- 0 Prefer Cold Drinks
- 0 Prefer Room Temperature Drinks
- 0 Prefer Hot Drinks

Temperature

- 0 Tend To Be Chilly
- 0 Tend To Be Hot
- 0 Experience Hot Flashes
- 0 Cold Weather Bothers You
- 0 Hot Weather Bothers You
- 0 Damp Weather Bothers You
- 0 Windy Weather Bothers You

Perspiration

- 0 Too Easily
- 0 Too Little
- 0 Profuse Sweating
- 0 Frequent Sweating
- 0 Night Sweats
- 0 Feet Sweating
- 0 Hands Sweating
- 0 Absence of Sweating

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Patient Information

First Initial and Last Name

Serious Illnesses

List *any* health issues *and* the *year(s)* they *affected* you.

Years

Illnesses You Had Requiring Hospitalization.

Illnesses You Had Not Requiring Hospitalization.

Eyes, Ears, Nose, and Throat

Eyes

0 Nearsightedness or Farsightedness
0 Blurred Vision
0 Dry, Burning and/or Itching Eyes
0 Eyes Water Excessively
0 Eyes Sensitive To Light
0 Night Blindness
0 Bloodshot, Hot and/or Puffy Eyes
0 Double Vision
0 Floating Spots Before Eyes
0 Other:

Ears

0 Ear Infections
0 Noises or Ringing in Ears
0 Ear Discharges
0 Loss of Hearing
0 Lots of Wax
0 Vertigo
0 Ear Congestion
0 Other:

Nose and Throat

0 Hay Fever, Sinusitis, and/or Runny Nose
0 Dry Mouth or Nose
0 Nose Bleeds
0 Cracks In Corners Of Mouth
0 Dry or Chapped Lips
0 Sour Throat or Tonsillitis
0 Canker Sores
0 Sore, Red or Cracked Tongue
0 Cold Sores or Herpes
0 Inability to Smell or Taste
0 Lots of Cavities and/or Toothaches
0 Bleeding Gums and/or Gum Infections
0 Hoarseness
0 Allergies
0 Chronic Congestion and/or Post Nasal Drip
0 Swollen Lymph Nodes
0 Sore Lymph Nodes
0 Sinus Headaches
0 Snoring
0 Other:
0 Approximate Date of Last Dental Exam:

Skin, Hair, and Nails

Skin

0 Acne or Pimples
0 Eczema/Dermatitis
0 Stretch Marks
0 Skin Rashes, Eruptions, and/or Boils
0 Hives and/or Itching
0 Skin Ulcers or Sores
0 Skin Bruises Easily
0 Dry Skin
0 Oily Skin
0 Psoriasis
0 Other:

Hair

0 Change in Hair Color/Texture
0 Hair Loss or Thinning
0 Dry, Coarse Hair or Split Ends
0 Other:

Nails

0 Nails Weak, Ridged, and/or Split Easily
0 Discolored Nails
0 Separation From Nail Bed
0 Other:

Sleep

0 Disturbing Dreams
0 Not Rested Upon Waking
0 Can't Stop Thinking
0 Difficulty Falling Asleep
0 Restless Sleep
0 Drowsiness During the Day
0 Other:

How Many Hours Do You Sleep Each Night?

Do You Usually Wake Up During the Night?

If Yes, What Time Do You Usually Wake Up?

Internal System

Cardiovascular

0 Heart Beats Fast or Irregularly
0 Tightness in Chest and/or Full Heavy Feeling in Chest
0 Dizzy or Weak When Standing Up
0 Swollen Feet, Ankles, Or Legs
0 Cold Hands or Feet
0 Hands or Feet Turn Blue and/or White
0 Varicose Veins, Phlebitis
0 Heart Murmur
0 High Blood Pressure
0 Low Blood Pressure

Respiratory

0 Cough Frequently
0 Spitting Up Mucus or Blood
0 Wheezing
0 Shortness of Breath
0 Chest Pain
0 Pneumonia, Bronchitis, or Pleurisy
0 Difficulty Breathing

Urinary

0 Frequent Urination
0 Difficulty Urinating
0 Get Up To Urinate At Night
0 Bedwetting
0 Incomplete Urination or Dribbling
0 Narrowing of Stream
0 Hard To Start Stream
0 Change In Color and/or Odor of Urine
0 Incontinence (Uncontrolled Urination)
0 Pain When Urinating, Burning
0 Bladder Infections
0 Kidney Infections
0 Kidney Stones
0 Other:

Gastrointestinal

0 Increased Appetite or Thirst
0 Loss of Appetite or Thirst
0 Difficulty Swallowing
0 Nausea or Vomiting
0 Bad Breath
0 Metallic or Bitter Taste in Mouth
0 Can Not Eat Fats or Greasy Foods
0 Jaundice
0 Heartburn/Acid Reflux
0 Indigestion or Distress
0 Gas or Belching
0 Bloating
0 Stomach or Abdomen Tender or Painful
0 Symptoms Relieved By Eating
0 Anorexia
0 Bulimia
0 Headache, Dizziness, or Irritability If Meals Are Skipped

0 Diarrhea or Loose Stool
0 Constipation
0 Alternating Constipation / Diarrhea
0 Light Colored or Greasy Stools
0 Dark Stools
0 Blood or Mucus In Stool
0 Feeling Of Incomplete Evacuation
0 Undigested Food In Stool
0 Foul Odor Of Stool or Gas
0 Hemorrhoids
0 Anal Itching and/or Bleeding
0 Use Laxatives
0 Other:

How Often Do You Have A Bowel Movement?

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Patient Information

First Initial and Last Name

Female Reproductive

How Old Were You During Your First Menstrual Period?

When Was Your Last Period?

Do You Currently Have Regular Menstrual Periods? O Yes O No

If No, When And Why Did It End?

If You Are Currently Having Menstrual Periods -

Is Your Cycle Regular? O Yes O No

What Are the Typical Number of Days In Your Cycle?

What is the Typical Duration of Your Flow?

Is the Color of Your Flow?
- 0 Pale Red
- 0 Dark Red
- 0 Bright Red
- 0 Purplish

Is the Amount of the Flow?
- 0 Light
- 0 Moderate
- 0 Heavy

Do You Have Any Type Of Pain During Your Cycle?
- 0 Before Flow
- 0 During Flow
- 0 After Flow

Do You Have Clots? 0 Yes 0 No

If You Have Pain During Your Period, Where Is It Located?

Is The Pain Relieved By:
- 0 Heat?
- 0 Cold?
- 0 Pressure?

Is The Pain Aggravated By:
- 0 Heat?
- 0 Cold?
- 0 Pressure?

Is The Pain:
- 0 Dull?
- 0 Sharp and Stabbing?
- 0 A Burning Sensation?
- 0 A "Bearing Down" Sensation?

Do You Experience Specific Emotions Around Your Period?
- 0 Depression
- 0 Sadness
- 0 Irritability
- 0 Other
- 0 Anger

Do You Have Bleeding Between Periods? 0 Yes 0 No

Have You Had Any (-Sections? 0 Yes 0 No

Do You Currently Use Birth Control? 0 Yes O No

If Yes, What Type of Birth Control?

Do You Have Recurring Yeast Infections? 0 Yes O No

How Many Pregnancies Have You Had?

How Many Children Have You Had?

Have You Had A Hysterectomy? 0 Full 0 Partial

Have You Had A History of Abnormal PAP Smears?

If Yes, Explain:

- 0 Symptoms Occur In Monthly Pattern
- 0 Diminished or Increased Sexual Desire
- 0 Painful Intercourse or Difficulty Having Orgasm
- 0 Pain, Discomfort, or Itching in Genital Area
- 0 Inability to Conceive
- 0 Vaginal Discharges
- 0 Hot Flashes
- 0 Fibroids
- 0 Ovarian Cysts
- 0 PID (Pelvic Inflammatory Disease)
- 0 Other:

Male Reproductive

- 0 Diminished or Increased Sexual Desire
- 0 Erectile Dysfunction
- 0 Prostate Problems
- 0 Pain, Lump, or Mass in Testicle
- 0 Discharge From Penis
- 0 Sores or Rashes in Genital Area
- 0 Infertility
- 0 Hernia
- 0 Other:

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Patient Information

First Initial and Last Name

Medicines and Supplements

If available, please bring your most *recent /ab/blood* work results to your first session. *Document* your *test levels of the following if known:*

Blood Pressure Cholesterol Level HDL LDL Triglycerides

What Prescription Medications Are You Currently Taking?

What Vitamins, Herbs, or Supplements Are You Currently Taking?

What Over The Counter Medications Are You Currently Taking?

0 Acetaminophen (Tylenol)
0 Aleve (Naproxen)
0 Antacids
0 Cough Medicine
0 Ibuprofen (Motrin, Advil)
0 Iron Pills
0 Have You Used Antibiotics?
Date of Last Use:

0 Laxatives
0 Sleeping Pills
0 Water Pills
0 Weight Reducing Pills
0 Other:
0 Other:
0 Other:

Life Style

Do You Smoke Cigarettes? 0 Yes 0 No How Many Packs Per Day?
Do You Drink Coffee? 0 Yes 0 No How Many Cups Per Day?
Do You Drink Alcohol? 0 Yes 0 No How Many Drinks Per Day?
Do You Drink Soda? 0 Yes 0 No How Many Cans and/or Bottles Per Day?

Diet

Do You Eat A Special Diet? If Yes, Please Describe:

Do You Have Any Cravings Or Strong Desires For Certain Foods? If Yes, Please Describe:

Do You Avoid Certain Foods? If Yes, Please Describe What and Why:

Do You Have Any Allergies or Adverse Reactions To Food? If Yes, Please Describe:

Have You Ever Been Tested For Allergies (Food or Environmental)? 0 Yes O No If Yes, What?

Exercise

Do You Get Regular Exercise? 0 Yes O No If Yes, How Often? If Yes, What Type?

Neurological/Psychological

0 Dizziness
0 Fainting and/or Blackouts
0 Seizures and/or Convulsions
0 Tingling or Numbness
0 Problems Walking
0 Lack of Coordination
0 Speech Problems
0 Poor Memory

0 Hard to Concentrate
0 Nervous Breakdown
0 Indecisiveness
0 Anxiety
0 Mood Swings
0 Worry Often
0 Depression
0 Irritability

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Patient Informatiorl

First Initial and Last Name

Pain

Where Are You Experiencing Pain?

Is The Pain Constant or Intermittent?

How Intense Is The Pain On A Scale of 1 to 10?

What Time Of Day Is The Pain The Worst?

How Long Does The Pain Last?

Does the Pain Move? 0 Yes 0 No

Does The Location of the Pain Feel Better or Worse With:

Cold?	0	Better	O	Worse
Heat?	0	Better	O	Worse
Pressure?	0	Better	O	Worse
Physical Activity?	0	Better	O	Worse
Rest	O	Better	O	Worse

Is The Sensation Of The Pain:

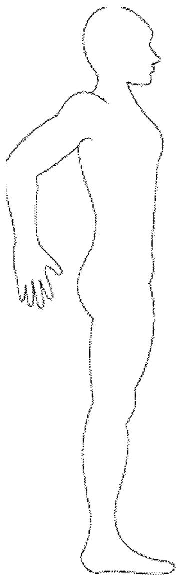
A Heavy Feeling? 0
Sharp and Stabbing? 0
Dull and Achy? 0
Electrical? 0
Other:

0 Swollen, Painful, and/or Stiff Joints
0 Fractures
0 Bone Pains
0 Tremors, Twitches, and/or Cramps

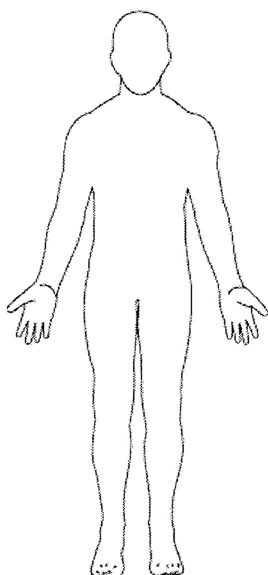
0 Loss Of Strength and/or Muscle Wasting
0 Any Numbness or Tingling
0 Other:

Please List Any Joint(s) Not Structurally Sound, Not Intact, Or Dislocates Easily?

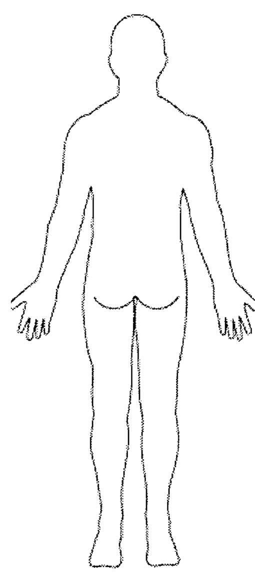
On the *models below* indicate *anywhere* you *are* experiencing pain *and/or* discomfort.
Mark With ***P*** *for* Pain
Mark With ***T*** *for* Tension
Mark With ***N*** *for Numbness*



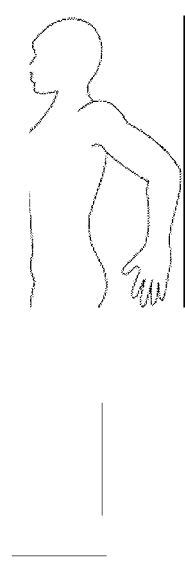
Right Side



Front



Back



Left Side

Hope Acupuncture
Rora Park
MAH, M, DiplAc, LAc

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, 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 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 the 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 the 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.

Signed Name: ______________________________ Date: ______________

Hope Acupuncture
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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Patient Name ______________________________

Patient Birth Date ______________________________

Health Insurance ID (Or Social Security Number) ______________________________

I understand that as part of my healthcare, or my legal dependent's healthcare, Hope Acupuncture creates and maintains health records describing health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as:

A basis for planning care and treatment.
A basis for communicating among the many healthcare professionals who contribute to care.
A source of information for applying diagnostic and medical information to a bill.
A means for a third-party payer to verify that services billed were actually provided.
A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand I have the following rights:

To object to the use of health information for directory purposes.
To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.
To request restrictions as to how this health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested.

I request the following restrictions to the use or disclosure of my health information:

____

____

____

______________________________ ______________ ______________________________
Patient or Legal Representative Signature | Date | Witness Signature

Hope Acupuncture
Rora Park
M.A.T.C.M., Dipl.Ac. L.Ac

Informed Consent

I hereby request and consent to the performance of acupuncture treatments and other procedures on me (or on the patient named below, for whom I am legally responsible) within the scope of the practice of the provider(s) of Hope Acupuncture and/or other licensed providers who now or in the future treat me while employed by, working or associated with, or serving as back-up for the provider named below, including those working at this office or any other office or clinic, whether signatories to this form or not.

I understand the methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, manual therapies such as myofascial realease and craniosacral therapy, Chinese or western herbal medicine and supplements, infrared devices, gua sha, therapeutic exercise, medical qigong and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not *move* while the needles are being inserted, retained, or removed. 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 Hope Acupuncture exclusively uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. 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, mineral, and animal 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. If there were any unanticipated or unpleasant effects associated with the consumption of the herbs I will immediately discontinue use, and I will immediately notify the provider. I will notify the provider who is caring for me if I am or become pregnant.

I do not expect the provider to anticipate and explain all risks and complications of treatment, and I wish to rely on the provider to exercise judgment during the course of treatment which the provider 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 office medical and administrative staff may review my medical 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, this 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's Printed Name: ______________________________

Patient's Signature: ______________________________ Date: ____________

To be completed by the patient's representative if the patient is a minor or is physically or legally Incapacitated:

Print Name of Patient Representative: ______________________

Signature of Patient Representative: ______________________ Date: __________

Relationship to Patient: ______________________

Name of Provider: Rora Park MATCM, L.Ac., Dipl. Ac.

Hope Acupuncture
Rora Park, M.A.T.C.M., Dip!.Ac, L.Ac.

Payment Agreement

Hope Acupuncture does its best to provide the highest level of health care. In order to provide the highest possible service, the following policies are in effect:

Hope Acupuncture accepts most insurance plans. As a courtesy, we will bill your insurance carrier for payment. We do expect you to pay any deductible and/or co-pay amount at the time treatment is administered. You authorize and request payments of medical benefits directly to your provider. Any amount remaining once the insurance company has responded will be billed to you.

Hope Acupuncture requires 12 hours advance notice of any cancellation or rescheduling of your appointment. All appointments that are cancelled, rescheduled or missed with less than 12 hours advance notice will be charged a $50 fee. Thank you for your cooperation.

By signing below, I acknowledge that I have read through, fully understand, and accept responsibility to follow the policies contained in this Payment Agreement with Hope Acupuncture.

Signed Name: ______________________________ Date: ______________