Integrative Healing
Jenny Crissman MS, L. Ac.
6536 Telegraph Avenue, Suite A201
Oakland, CA 94609
510.595.0700
License AC #8897

Name: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Date of Birth: ____________________

Height: __________ Weight: __________

Sex: ____________________

Home Phone: ____________________

Cell Phone: ____________________

Work Phone: ____________________

Email: ____________________

Employer: ______________________________

Emergency Contact: ______________________________

Phone: ____________________

Insurance: ______________________________

Policy Number: ______________________________

Group Number: ______________________________

How did you hear about us? ______________________________

THANK YOU!

Integrative Healing
Jenny Crissman L. Ac.
6536 Telegraph Ave. STE.A201
Oakland,CA 94609
(510) 595-0700
License #8897

FINANCIAL AGREEMENT

By signing this document, I acknowledge that I am about to receive health care services and understand that I am directly responsible for all my health care bills incurred at this office for services rendered.

This agreement is made solely for the provider's protection. The provider may agree to wait for payment providing that there continues to be a reasonable probability (determined by the provider) that payment will be made either by insurance proceeds or out of the settlement of liability. If claims are denied however, the patient is responsible for payment in full.

PATIENT
SIGNATURE
(parent/guardian if a minor) ______________________________

DATE
____

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 California 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 the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the National Arbitration Form 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**

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

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 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 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.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative)

(Indicate relationship if signing for patient)

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

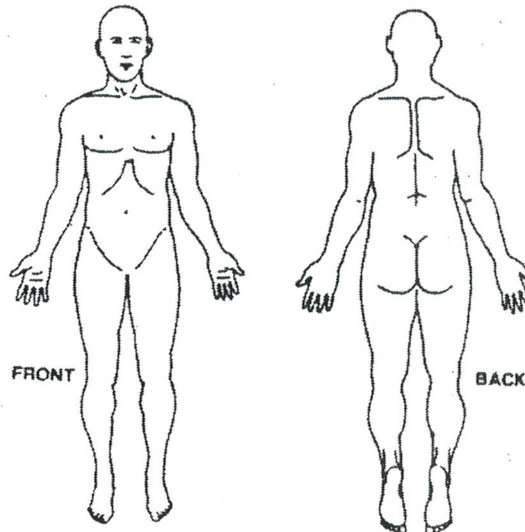
COMPREHENSIVE ACUPUNCTURE EXAMINATION

NOTE: This is a confidential record of your medical history and will be kept in this office.
Information contained here will not be released to any person without your authorization

NAME:____________________ Date __________ Time ______ Account No__________

Birth Date:________ Height ________ Weight ________

PLEASE MARK YOUR AREAS OF PAIN



Major Complaint/s:____________________

Other Complaint/s:____________________

Date of onset (when you first noticed the problem)?__________

Pain is: ☐ Minimal ☐ Slight ☐ Moderate ☐ Severe

How long have you have this condition?__________

How you had this in the past? ☐ Yes ☐ No When?__________

What makes it better?__________

What makes it worse?__________

Is your condition: ☐ Getting worse ☐ Constant ☐ Comes and Goes

Medications/Drus/Herbs you are currently taking:____________________

List Surgeries/Operations you have had and dates:____________________

Date of your last physical examination:__________ By whom?__________

MEDICAL HISTORY: (Do you have or have you ever had)?

☐ Cancer ☐ Diabetes ☐ Epilepsy ☐ Stroke ☐ Kidney or bladder trouble ☐ Gallstones ☐ Ulcers ☐ High Blood Pressure

☐ Chronic Fatigue ☐ Hepatitis ☐ Jaundice ☐ Sudden Weight Loss ☐ Sudden Weight Gain

Other:____________________

FAMILY HISTORY: (Has any member of your family had any of the above)? ☐ Yes ☐ No If yes, which member and what did they have?____________________

ENERGY LEVEL: High (Time of day)__________ Low (Time of day)__________

STRESS: ☐ None ☐ Moderate ☐ Severe What causes it?__________

SWEATING: ☐ Night sweats ☐ Rarely sweat ☐ Excess sweating __________

CIRCULATION: Feeling of ☐ Hot ☐ Cold What area? __________

SKIN: ☐ Dry ☐ Itchy ☐ Moist/clammy ☐ Burning ☐ Changing moles or lumps (cysts/tumors) ☐ Boils ☐ Acne

☐ Frequent skins rashes ☐ Hair loss/thinning ☐ Dry scalp ☐ Skin puffy/wrinkled ☐ Bruises easily (blank and blue spots)

☐ Hives Other:____________________

SCARS: (List ALL scars from accidents or surgeries)____________________

SLEEP PROBLEMS: ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Restful ☐ Excess dreaming

Other:__________ How many hours do you sleep a night?__________

HEAD: Headaches (what area?)__________ ☐ Dizziness ☐ Memory Loss ☐ Loss of balance

Other:

EYES: ☐ Eye Pain ☐ Dry Eyes ☐ Blurred vision ☐ Darkness under eyes Other:______

EARS: ☐ Poor hearing ☐ Earaches ☐ Ear discharge/infections ☐ Ringing/buzzing in ears

Other:______

NOSE: ☐ Frequent nose bleeds ☐ Sinus trouble ☐ Frequent colds Other:______

THROAT: ☐ Sore throat ☐ Hoarseness ☐ Difficulty swallowing ☐ Jaw problems ☐ Teeth/gum problems ☐ Swollen tongue

Other:______

CHEST: ☐ Hard to breathe ☐ Wheezing ☐ Shortness of breath ☐ Mucus rattles when breathing ☐ Trouble breathing at night

☐ Pain/pressure in chest ☐ Palpitations ☐ Persistant cough ☐ Coughing blood ☐ Coughing phlegm

Sputum color______ Consistency______

Other:______

BLOOD PRESSURE: ☐ High ☐ Low ☐ Do not know

BOWELS: ☐ Diarrhea ☐ Constipation ☐ Bloody stools ☐ Black stools ☐ Mucus in stools ☐ Hemorrhoids

☐ Lower bowel gas ☐ Stools have foul odor ☐ Colon problems Number of bowel movements a day ______

Other:______

URINE: Color______ Amount______ Frequent urination ☐ Daytime ☐ At night

☐ Strong smelling urine ☐ Hard to urinate ☐ Pain or burning on urination ☐ Blood in urine ☐ Frequent infections

☐ Water retention Other:______

MUSCULOSKELETAL: Pain in: ☐ Neck ☐ Shoulder ☐ Between shoulders ☐ Arms/hands ☐ Hip ☐ Knee ☐ Fingers

☐ Big toe ☐ Upper back ☐ Mid back ☐ Lower back ☐ Bones sore/painful ☐ Loss of grip ☐ Swollen knees/elbows

☐ Leg cramps at night ☐ Weakness in legs ☐ Weak ankles ☐ Stiff all over ☐ Tingling in feet ☐ Painful joints ☐ Bursitis

☐ Muscles spasm/cramps ☐ Loss of feeling in hands/feet Other:______

NEUROLOGICAL: ☐ Nervousness ☐ Depressed ☐ Easily irritated ☐ Frequent crying ☐ Worry/Anxiety ☐ Mood swings

☐ Memory confusion ☐ Poor concentration ☐ Suicidal ☐ Tremors ☐ Numbness/tingling in limbs ☐ Poor coordination

☐ Muscle weakness ☐ Feel weak and shaky ☐ Seizures ☐ Neuralgia (nerve pain) ☐ Shingles Other:______

FEMALES: Pregnant? ☐ Yes ☐ No Last monthly period______ Last PAP test______

Form of birth control: ☐ None ☐ Pill Other:______

Age started menstrual cycle______ Age stopped______ ☐ Mentrual Pain ☐ Low backache

☐ Irregular ☐ Clotting ☐ Heavy bleeding ☐ Light scanty bleeding Color______

☐ Water retention ☐ Mood changes ☐ Miss periods ☐ Low or no sex drive ☐ Painful breasts ☐ Hot flashes

☐ Food cravings Other:______

Discharges: ☐ Yellow ☐ Thick ☐ White ☐ Odor ☐ Itching ☐ Liquid Other:______

No. Pregnancies______ No. Deliveries______ No. Miscarriages______ No. Abortions______

No. Cesareans______ Operations: ☐ Cervix ☐ Uterus ☐ Ovaries Other:______

MALES: ☐ Low sexual drive ☐ Lack of sexual drive ☐ Impotence ☐ Ejaculation causes pain ☐ Discharge

☐ Pain or burning while urinating ☐ Premature ejaculation ☐ Prostate trouble Other:______

APPETITE: ☐ Excessive appetite ☐ Poor appetite ☐ Appetite keeps changing ☐ Feel tired or weak if a meal is missed

☐ Excessive thirst ☐ Never thirsty Other:______

Specific food cravings? ☐ Yes ☐ No If yes, what?______

Other:______

Do you use: Alcohol? ☐ Yes ☐ No Amount per week ______ Type ______

Tobacco? ☐ Yes ☐ No Packs per day ______ How many years ______

DO YOU:

Eat raw fruits or vegetables at least twice a day? ☐ Yes ☐ No

Eat green or yellow vegetables at least twice a day? ☐ Yes ☐ No

Eat frequently between meals? ☐ Yes ☐ No

Chew your food thoroughly before swallowing it? ☐ Yes ☐ No

Drink juice, milk or other drinks instead of water when thirsty? ☐ Yes ☐ No

Always add salt at the table? ☐ Yes ☐ No

Eat meat or dairy products 2 or more times a day? ☐ Yes ☐ No

Eat the same foods almost every day? ☐ Yes ☐ No

Eat when you are not hungry? ☐ Yes ☐ No

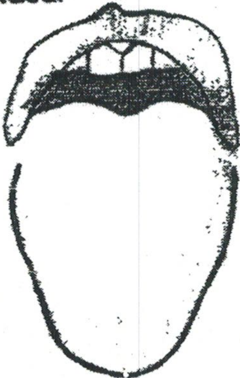
Eat until you feel full? ☐ Yes ☐ No

Occasionally go on a "crash" diet? ☐ Yes ☐ No

Patient's Signature ______

EXAMINATION

TONGUE:



Color ______

______

______

Coat ______

______

______

______

Body ______

______

______

______

PULSE

RIGHT	LEFT
______	______
______	______
______	______

GENERAL CHARACTER

______

______

______

TEMPERATURE: ______

BLOOD PRESSURE: ______

APPEARANCE: ☐ Excellent ☐ Good ☐ Fair ☐ Well-nourished ☐ Undernourished ☐ Debilitated ☐ Thin ☐ Husky ☐ Overweight ______

MOVEMENT: ☐ Guarded ☐ Slow ☐ Impaired ☐ Needs assistance ☐ Deformity ______

______

SKIN COLOR: ______ FACIAL COLOR: ______ EYES: ______

______

AREA CLIMATE: Body odors ______ Smell ______

______

ABDOMEN (by palpation): ☐ Organ swelling ☐ Masses ☐ Hernia ☐ Pain ______

______

______

ABDOMINAL REFLEX(es): ______

______

______

ASSESSMENT/EVALUATION/FINDINGS: (Internal, emotional, dietary, channel disorders, trauma, constitution, inactivity, overworked, etc.)

______

______

______

______

______

EIGHT PRINCIPLES: (Yin/Yang, Internal/External, Hot/Cold, Deficient/Excess) ______

______

______

______