Water of Life Naturopathic Healthcare

NEW PATIENT INTAKE FORM

PERSONAL IDENTIFIABLE INFORMATION (PII)					
Name:				**Today's Date:**	
Address:		**City:**		**State:**	**Zip:**
Phone #:	**Home:**	**Cell:**		**Work:**	
Birth Date:	**Age:**	**Height:**	**Weight:**	**Sex:**	**Marital Status:**
Emergency Contact's Name & Phone #:					

TREATMENT INQUIRY
Reason for Visit Today:
How long have you had this condition?
Is it getting worse? **Does it both your: Sleep ☐ Work ☐ Other (specify) ☐**
What seems to be the initial cause?
What seems to make it better?
What seems to make it worse?
Have you had acupuncture before? ☐ Yes ☐ No Chinese Herbal Medicine? ☐ Yes ☐ No
Are you under the care of a physician now? ☐ Yes ☐ No If yes, for what?
Physician's Name: Physician's Phone #:

HEALTH INSURANCE INFORMATION			
Name of Insurance:			**Policy #**
Address:	**City:**	**State:**	**Zip:**
Phone #:			
MEDICARE INFORMATION			
Name of Insurance:			**Policy #**
Address:	**City:**	**State:**	**Zip:**
Phone #:			

FAMILY MEDICAL HISTORY			
☐Arteriosclerosis	**☐Cancer (type _____)**	**☐Diabetes (type_____)**	
☐Asthma	**☐Heart Disease**	**☐Stroke**	**☐Seizures**
☐Alcoholism	**☐Depression**	**☐High Blood Pressure**	
Allergies (List):			

YOUR DIET				
Appetite: ☐ Low ☐ High	**Protein Intake: ☐Low ☐ High**	**☐ Coffee/Tea**	**☐ Artificial Sweeteners**	
☐ Soft Drinks/Fruit Juices	**☐ Sugar**	**☐ Salty Foods**	**☐ Water (# glasses per day:**	

PRACTITIONER USE ONLY:

Created: January, 2022 clj

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AVERAGE DAILY MENU					
Morning	**Snack**	**Noon**	**Snack**	**Evening**	**Snack**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
Pharmaceutical taken in the last 2 months:					
Vitamins/Supplements taken in the last 2 months:					

YOUR PAST MEDICAL HISTORY				
Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.				
☐ **AIDs/HIV**	☐ **Diabetes (type _____)**	☐ **Multiple Sclerosis**	☐ **Tuberculosis**	☐ **Mumps**
☐ **Alcoholism**	☐ **Typhoid Fever**	☐ **Emphysema**	☐ **Allergies**	☐ **Ulcers**
☐ **Epilepsy**	☐ **Pacemaker (date: _____)**	☐ **Rheumatic Fever**	☐ **Pleurisy**	☐ **Goiter**
☐ **Appendicitis**	☐ **Venereal Disease**	☐ **Whooping Cough**	☐ **Pneumonia**	☐ **Gout**
☐ **Heart Disease**	☐ **Arteriosclerosis**	☐ **Thyroid Disorders**	☐ **Asthma**	☐ **Polio**
☐ **Birth Trauma**	☐ **Hepatitis (type _____)**	☐ **High Blood Pressure**	☐ **Measles**	☐ **Stroke**
☐ **Chicken Pox**	☐ **Herpes (type_____)**	☐ **Scarlet Fever**	☐ **Seizures**	☐ **Cancer**
☐ **Surgery (list)**				
☐ **Major Trauma (car, fall, etc., list)**				
☐ **Birth on your own**		☐ **Other (specify)**		

YOUR LIFESTYLE					
☐ **Alcohol**	☐ **Marijuana**	☐ **Stress**	☐ **Tobacco**	☐ **Drugs**	☐ **Occupational Hazards**
Regular Exercise: Type:			**Frequency:**		

GENERAL SYMPTONS				
☐ **Poor Appetite**	☐ **Poor Sleep**	☐ **Bodily Heaviness**	☐ **Chills**	☐ **Bleed or Bruise Easily**
☐ **Heavy Appetite**	☐ **Heavy Sleep**	☐ **Cold hands or feet**	☐ **Night Sweats**	☐ **Peculiar Taste (describe)**
☐ **Strongly like cold drinks**	☐ **Dream-disturbed Sleep**	☐ **Poor Circulation**		☐ **Sweat Easily**
☐ **Strongly like hot drinks**	☐ **Fatigue**	☐ **Shortness of Breath**		☐ **Muscle Cramps**
☐ **Recent weight loss/gain**	☐ **Lack of Strength**	☐ **Fever**		☐ **Vertigo or dizziness**

RESPIRATORY			
☐ **Difficulty Breathing when lying down**	☐ **Tight Chest**	☐ **Cough (wet or dry)**	☐ **Pneumonia**
☐ **Color of Phlegm (thick or thin)**	☐ **Coughing up Blood**	☐ **Shortness of Breath**	☐ **Asthma/wheezing**
☐ **Difficult Inhalation/Exhalation**			

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NEW PATIENT INTAKE FORM

HEAD, EYES, EARS, NOSE, THROAT				
☐ Glasses (what age)	☐ Night Blindness	☐ Gum Problems	☐ Recurrent Sore Throat	☐Headaches
☐ Eye Strain	☐ Myopia or Presbyopia	☐ Sores on Lips or Tongue	☐ Swollen Glands	☐ Migraines
☐ Eye Pain	☐ Glaucoma	☐ Dry Mouth	☐ Lumps in Throat	☐ Concussions
☐ Red Eyes	☐ Cataracts	☐ Excessive Saliva	☐ Enlarge Thyroid	☐ Head Problem
☐ Itchy Eyes	☐ Teeth Problems	☐ Sinus Problems	☐ Nosebleeds	☐ Neck Problem
☐ Spots in Eyes	☐ Grinding Teeth	☐ Excessive Phlegm Color:	☐ Ringing in Ears (high or Low)	
☐ Poor Vision	☐ TMJ	☐ Poor Hearing	☐ Earaches	
☐ Blurred Vision	☐ Facial Pain			

CARDIOVASCULAR				
☐ High Blood Pressure	☐ Low Blood Pressure	☐ Chest Pain	☐ Tachycardia	☐ Phlebitis
☐ Difficulty Breathing	☐ Heart Palpitations	☐ Fainting	☐ Blood Clots	☐ Irregular Heartbeat

GASTRONINTESTINAL				
☐ Nausea	☐ Diarrhea	☐ Intestinal Pain or Cramping	☐ Vomiting	☐ Constipation
☐ Burning Anus	☐ Black Stools	☐ Acid Regurgitation	☐ Rectal Pain	☐ Gas
☐ Bloody Stools	☐ Anal Fissures	☐ Mucous in Stools	☐ Hiccup	☐ Bloating
☐ Hemorrhoid	☐ Bad Breath	☐ Itchy Anus	☐ Laxative use What kind?	
How often?	☐ Bowel Movements Frequency:	Texture/Form:	Color:	Odor:

MUSCULOSKELETAL			
☐ Neck/Shoulder Pain	☐ Upper Back Pain	☐ Joint Pain	☐ Limited Range of Motion
☐ Muscle Pain	☐ Low Back Pain	☐ Rib Pain	☐ Limited Use
☐ Other (describe)			

SKIN AND HAIR					
☐ Rashes	☐ Eczema	☐Dandruff	☐ Change in Hair/Skin Texture	☐Hives	☐ Psoriasis
☐ Itching	☐ Ulcerations	☐ Acne	☐ Fungal Infections	☐ Hair Loss	
☐ Other Hair or Skin Problems (describe)					

NEUROPSYCHOLOGICAL				
☐ Seizures	☐ Poor Memory	☐ Irritability	☐ Numbness	☐ Considered/Attempted Suicide
☐ Depression	☐ Easily Stressed	☐ Ties	☐ Anxiety	☐ Seeing a therapist
☐ Abuse Survivor		☐ Other (Specify)		

GENITOURINARY				
☐ Pain on Urination	☐ Blood in Urine	☐ Venereal Disease	☐ Increased Libido	☐ Impotence
☐ Frequent Urination	☐ Unable to hold Urine	☐ Bedwetting	☐ Decreased Libido	☐ Kidney Stone
☐ Premature Ejaculation	☐ Urgent Urination	☐ Wake to Urinate	☐ Nocturnal Emission	

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GYNECOLOGY			
☐ Age menses began	☐ Duration of flow	☐ Irregular Periods	☐ Painful Periods
☐ Vaginal Discharge	☐ Vaginal Sores	☐ Vaginal Odor	☐ Date of last PAP
☐ Breast Lumps	☐ # Pregnancies	☐ # Live Births	☐ # Premature Births
☐ Clots	☐PMS	☐ Age at Menopause	☐ Date last period began
Length of cycle (day 1 to day 1)			
Other:			

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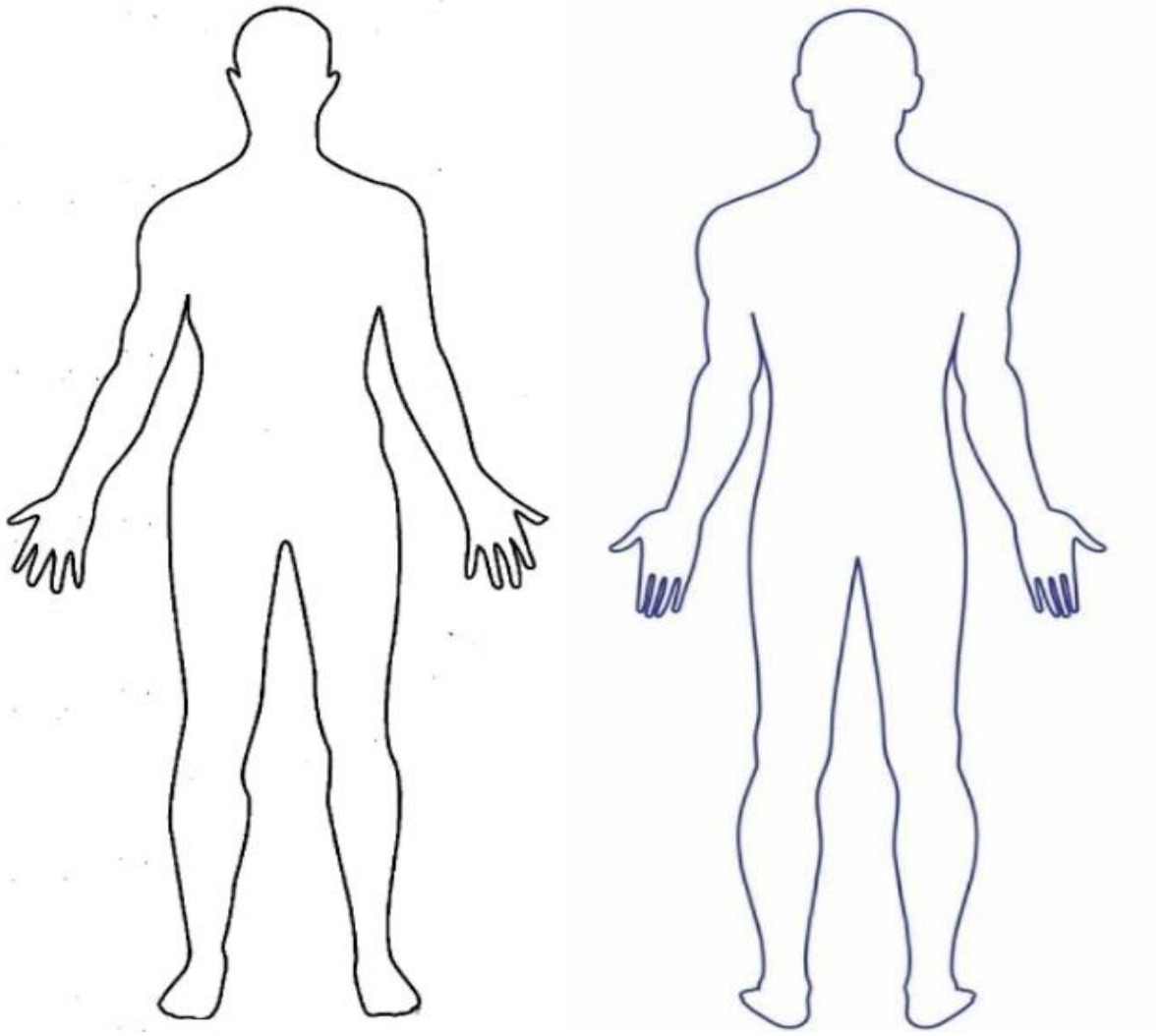
Indicate the location of your pain by using the letters to indicate your areas of pain.

P = Pain T = Tingling N= Numbness B = Burning S = Stiffness

Front **Back**



Water Of Life NaturoPathic Healthcare

New Patient Office Policy

Water Of Life Naturopathic Healthcare is a cash office. Therefore, payment is expected at time of service. If you are unable to pay in full, you will be asked to sign a payment plan and credit card information is required.

- Initial consultation = $195
- Initial cancer consultation = $235
- Acupuncture visits = $85 per visit
- Follow up visits = $85
- Phone follow-up consultations = $85
- NOTE: Specific tests and treatment procedures carry varying charges. These will be discussed with you.

Check which method of payment you prefer:

☐ Cash ☐ Check ☐ Charge

We also have a 24-hour cancellation/reschedule policy. If you do not call the Medical Clinic within 24 hours prior to your scheduled appointment, you will be charged half the office visit fee for the appointment.

By signing below, I agree that I have read and understood this policy. I guarantee payment of all charges incurred as a patient of Water of Life NaturoPathic Healthcare.

Signed:	Date:
Printed Name:	
Parent or Guardian (minor)	Date:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including 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 Agreements.

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 received 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	**DATE:**
Or Patient Representative:	**Relationship to Patient:**

OFFICE SIGNATURE: **DATE:**

ALSO, YOU WILL NEED TO READ AND SIGN THE INFORMED CONSENT ON REVERSE SIDE.

Water of Life Naturopathic Healthcare
NEW PATIENT INTAKE FORM

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 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 simulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consume 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 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.

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 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 it 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:

PATIENT SIGNATURE:	**Date:**
Or Patient Representative:	**Relationship to Patient:**