Elements Holistic Wellness

Acupuncture and Massage Therapy

Massage & Acupuncture Intake

Date: ___________
☐ **New Patient**
☐ **Patient Update**

Patient Name: ____ **Date of Birth:** __________________
Address: ____________________________________ **City/Zip:** ____________________________________
Email: _______________________@________________ **Primary Phone #:** _____________________________
Occupation: _____________________________________ **Employer:** __________________________________

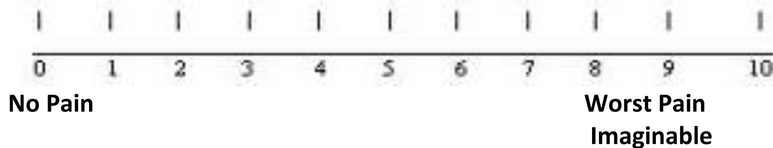
Our automated reminder system places 2 reminders. Please circle your preference below & provide # or email.
(7 days before appointment) **Reminder 1: Voicemail Text Email** ________________________________
(2 days before appointment) **Reminder 2: Voicemail Text Email** ________________________________

Insurance Company ______________________ **ID #**__________________________ **Group #** _______________
Responsible Party: __________________________ **Relationship to Primary Insured:** ☐ **Self** ☐ **Spouse** ☐ **Child**

Please check all the following that apply to you:

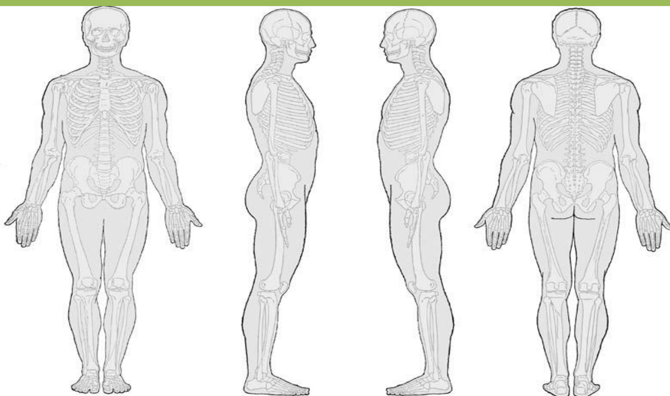
☐ Allergies to lotions/oils
☐ Arthritis or Rheumatoid Arthritis
☐ Artificial Joints
☐ Back Joint or Muscle Problems
☐ Blood Clots/Deep Vein Thrombosis
☐ Bruising (Easily)
☐ High Blood Pressure
☐ Broken Bones _________________
☐ Cancer/Tumor _________________
☐ Carpal Tunnel
☐ Depression
☐ Dizziness /Fainting
☐ Fatigue
☐ Fibromyalgia
☐ Heart Attack/ Heart Disease
☐ Osteoporosis
☐ Pacemaker
☐ Palpitation / Arrhythmia
☐ Pregnant # ________ weeks
☐ Recent Fractures/Sprains
☐ Recent Personal Injury
☐ Swelling of Feet/ Ankles
☐ Tennis / Golfer Elbow
☐ TMJ
☐ Trouble walking/balancing
☐ Varicose Veins

Please place a mark at the level of your pain on the scale:



No Pain **Worst Pain Imaginable**

Please mark your symptoms on the body diagram below.



Circle Areas Of Pain - Use Letters To Mark Type of Pain:
N - Numbness **T** - Tingling **W** – Weakness **B** – Burning **S**- Stabbing

What is the reason for your visit today?

____

Is it work or accident related? ☐ Yes ☐ No

Do you have pain today? ☐ Yes ☐ No

Pain or Numbness in: ☐ Hip ☐ Neck ☐ Arm
☐ Low back ☐ Feet ☐ Leg ☐ Shoulder
☐ Other __________________________________

How often are your symptoms present?
☐ Constantly ☐ Frequently
☐ Intermittently ☐ Occasionally

Are you experiencing any of the following?
☐ Flu or Cold Symptoms ☐ Sleep Problems
☐ Stiff/Painful Joints ☐ Headache

Describe your current health condition:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Name: ________________________ DOB: ____________

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15 82nd Dr. Suite 100, Gladstone, OR 97027 P: 503-656-5510

Have you had acupuncture? ☐ Yes ☐ No **Do you have any concerns?** ______________________________

Are you seeing a doctor for your current concern? ☐ Yes ☐ No **Primary Care Doctor:** ____________________

Please describe your current health problems: ____

How & when did your condition begin? ____

List any hospitalizations & surgeries: ____

____

What treatments have you received for the conditions above? ☐ Acupuncture ☐ Massage

☐ Surgery ☐ Chiropractic ☐ Injections ☐ Physical Therapy ☐ Medications: __________________

Do you eat a special diet? ☐ Yes ☐ No **Do you exercise regularly?** ☐ Yes ☐ No

Do you have any allergies? ☐ Yes ☐ No **List allergies and reactions:** ______________________________

____

Please list any medication(s), herbs, and or supplements you are taking: _____________________________

____

Please Check All The Following That Apply To You:

- ☐ **Alcohol/Drug Dependence**
- ☐ **Abnormal Menstruation**
- ☐ **Abnormal Weight Gain/Loss**
- ☐ **Anemia**
- ☐ **Anxiety**
- ☐ **Angina**
- ☐ **Asthma**
- ☐ **Auto Immune** ______________
- ☐ **Blood Disorder**
- ☐ **Blood in Stool**
- ☐ **Breast Lumps**
- ☐ **Cataracts**
- ☐ **Change in Bowel Movements**
- ☐ **Chest Pain/Heaviness w/activity**
- ☐ **Convulsions/ Seizures**
- ☐ **Death/Loss in past year**
- ☐ **Diabetes**
- ☐ **Diarrhea/ Constipation**
- ☐ **Excessive Thirst**
- ☐ **Fallen in past year**
- ☐ **Frequent Urination**
- ☐ **Glaucoma**
- ☐ **Heartburn/ Indigestion**
- ☐ **Heavy Coughing**
- ☐ **High Blood Pressure**
- ☐ **High Cholesterol**
- ☐ **Infertility/Miscarriage**
- ☐ **Kidney Disease**
- ☐ **Liver Problems**
- ☐ **Peptic Ulcer**
- ☐ **Pain at Night**
- ☐ **Prostate Problems**
- ☐ **Recent Divorce/Separation**
- ☐ **Retirement/ Job Change**
- ☐ **Shortness of Breath**
- ☐ **Significant Illness**
- ☐ **Sinusitis**
- ☐ **Tobacco Use Type?** _________
- ☐ **Quit Smoking When?** ________
- ☐ **Trouble Sleeping**
- ☐ **Trouble with Ears or Hearing**
- ☐ **Thyroid Disease/Disorder**

If a family member has any of the following please mark with your relationship below.

(M) Mother *(F) Father*
(S) Sister *(B) Brother*
(MG) Maternal Grandparent
(PG) Paternal Grandparent

Cancer ________________________
Heart Disease __________________
Hypertension ___________________
Lupus _________________________
Other _________________________

Current Health Stats:

Blood Pressure: ______________

Temperature: ________________

Height: ______________________

Weight: ______________________

Name: __________________________ DOB: _____________

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Office Policies, Financial Agreement & Insurance Billing Consent:

I hereby authorize Elements Holistic Wellness to release any medical information necessary to process claims with any insurance companies. I also assign to Elements Holistic Wellness payments to which I am entitled for services reported herewith.

I understand that I am financially responsible for all charges whether covered by insurance or not. **I understand that Insurance coverage & benefits quoted by EHW are only estimates.** If insurance denies the claim or fails to sufficiently reimburse the amount of billed services, I am responsible for all treatment and payment of all bills not covered by your insurance. Bills under patient responsibility will be discounted by the amount of the Insurance Contract. I will notify Elements immediately upon changes in my health plan coverage. If my account is assigned to an attorney for collection and/or suit due to delinquency, the prevailing party shall be entitled to reasonable attorney's fees and cost for collection.

A fee of $35 will be charged for missed appointments without a 24 hour notification of cancellation.

I authorize Elements Holistic Wellness to provide acupuncture and massage services to me. I understand that Elements Holistic Wellness may need to contact my primary care provider (PCP) if my condition needs to be co-managed. Therefore, I give my authorization to Elements Holistic Wellness to contact my medical doctor if necessary.

Signature: ____ **Date:** ________________________

Privacy Practices: HIPPA (Health Insurance Portability & Accountability Act)

Each time you receive a treatment at Elements Holistic Wellness, a record is made. Records may contain your symptoms, examination observations, test results, diagnoses, treatments & future treatment plans. Understanding your health information & how it is used helps to ensure it is accurate, used & disclosed appropriately & that you make informed decisions when authorizing disclosure to others. Per HIPPA all clinics are required to provide patients with their privacy practices. This describes how medical information about you may be used and disclosed and how you can get access to this information.

No information about your condition will be given to employers, friends or relatives without your permission
(except if required by court of law). We want to you fully understand your condition and your treatment. If you do not understand something, please feel free to ask questions. Also, your suggestions or complaints are important to us because we are interested in ways that we might improve our services.

By my signature below, I acknowledge that I have been notified of the availability of the Privacy Practices, but decline a copy at this time, knowing it will be provided to me if requested.

OPTIONAL: Furthermore, I authorize the acupuncturist and or office staff to discuss my health condition with the designated individual(s) below (i.e. guardian, spouse, or primary care physician) who may request/need to be informed about my condition.

NAMES AND RELATIONSHIPS OF ALLOWED INDIVIDUALS who may access my information:

____

Signature: ____ **Date:** ________________________
Relationship to Patient: ☐ **Self** ☐ **Parent** ☐ **Guardian**

Would you like a copy of our Privacy Practices Policy? ☐ YES ☐ NO

Name: __________________________ DOB: _____________

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MASSAGE THERAPY INFORMED CONSENT

If you have certain medical conditions or symptoms, massage therapy may be problematic for you. A referral from your primary health care provider may be required prior to treatment being provided.

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If at any point during the massage I am uncomfortable or uneasy with the procedures being administered and/or if I experience pain, **I understand it is my responsibility to IMMEDIATELY inform the massage therapist, so that the procedures can be adjusted to a level of comfort or terminated.**

I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I agree to keep to the following rules on each visit:

Before each treatment

- Tell your therapist about any changes in your health since your last visit.
- Draping will be used during the session – only the area being worked on will be uncovered.
- Chair massage is performed over clothing.

And throughout your visit

- Please ask questions about the procedures. Your therapist will be happy to keep you informed and comfortable.
- Always inform your therapist immediately upon any pain or discomfort.
- Refrain from making illicit or sexually suggestive remarks or actions:

Any such behavior will result in immediate termination of the treatment.

I authorize Elements Holistic Wellness to provide massage services to myself or my child under 17 years of age. I have been given time to ask questions.
By signing: **I agree with, consent to and understand all the conditions stated above.**

Patient Name: ____ **Date:** ____________________________

Signature: ___________________________ **Relationship to Patient:** ☐ **Self** ☐ **Parent** ☐ **Guardian**

Name: ___________________________ DOB: ______________

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Acupuncture Informed Consent for 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, 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 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 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.

Signature: ____

Date: ________________________ **Relationship to Patient:** ☐ **Self** ☐ **Parent** ☐ **Guardian**

PATIENT NAME:

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.

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 arbitr ted 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