SERENITY ACUPUNCTURE, INC. – JENNIFER FREY, L.AC, EAMP
370 RIVER ROAD * SEQUIM, WA 98382 * 360-683-8550 * JFREYLAC@GMAIL.COM
WWW.SERENITYACUPUNCTURECLINIC.COM

Confidential Patient Intake Form

Today's Date:_____

Information contained in this form is considered strictly confidential. Your responses are important to better understand the health issues you face and ensure the delivery of the best possible treatment.

Name:_____ Date of Birth:_____ Age:_____ ❑ Male ❑ Female

What would you like to be called in our office? _____

Address:_____City/State:_____ Zip:_____

Phone #1 _____ Phone #2_____ Phone #3_____

Email: _____ Occupation: _____ Employer: _____

Marital Status: _____ How did you hear about us? _____

Emergency Contact – Name: _____ Relationship: _____ Phone: _____

****

Give a brief detailed description of the primary issue(s) you are currently experiencing:

_____

_____

_____

What seemed to be the initial cause? _____ Is this condition: ❑Getting Worse ❑ Better ❑Same

When did the condition begin? _____

Is the condition interfering with: ❑Work ❑Sleep ❑Daily Routine ❑Other: _____

Have you had this or similar conditions in the past? ❑Yes ❑No - Comments: _____

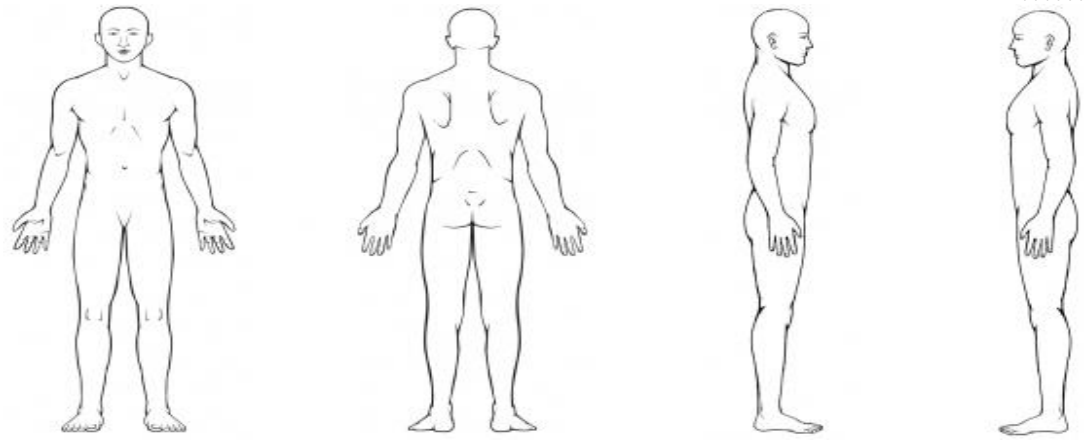
What seems to make this issue better? _____ worse? _____

Other issues you would like addressed: _____

****

Please indicate your area(s) and type(s) of pain on the figures below:

numbness ---------- pins & needles oooooooo burning xxxxxxxx aching ******** stabbing //////////



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

No pain _____ worst possible pain

Other doctors/therapists that have treated this condition: _____

Have you been given a diagnosis? ❑Yes ❑No – If yes what was it? _____

Family physician's name (if you have one): _____Date of last physical exam: _____

Was this the result of a work or auto injury? ❑Yes ❑No – Comments: _____

Review of Health History

Name:_____

Please check the corresponding boxes if you have the condition now or have had it in the past.

General	Now	Past
Weakness	❑	❑
Fatigue	❑	❑
Fever	❑	❑
Chills	❑	❑
Night Sweats	❑	❑
Fainting	❑	❑
Skin		
Color Changes	❑	❑
Nail Changes	❑	❑
Hair Changes	❑	❑
Moles	❑	❑
Rashes	❑	❑
Eczema	❑	❑
Psoriasis	❑	❑
Acne	❑	❑
Head		
Headache	❑	❑
Injuries	❑	❑
Bumps	❑	❑
TMJ Dysfunction	❑	❑
Eyes		
Last Eye Exam:		
Glasses	❑	❑
Contact Lenses	❑	❑
Cataracts	❑	❑
Glaucoma	❑	❑
Change in Vision	❑	❑
Ears	❑	❑
Deafness	❑	❑
Ringing	❑	❑
Discharge	❑	❑
Earache	❑	❑
Dizziness	❑	❑
Vertigo	❑	❑
Nose		
Decreased Smell	❑	❑
Bleeding	❑	❑
Pain	❑	❑
Discharge	❑	❑
Obstruction	❑	❑
Runny Nose	❑	❑
Sinus Congestion	❑	❑
Mouth		
Bleeding Gums	❑	❑
Sores	❑	❑
Dental Problems	❑	❑
Bad Breath	❑	❑
Loss of Taste	❑	❑
Dry Mouth	❑	❑
Throat		
Soreness	❑	❑
Tonsillitis	❑	❑
Hoarseness	❑	❑
Trouble Swallowing	❑	❑

Neck	Now	Past
Stiffness	❑	❑
Soreness	❑	❑
Enlargement	❑	❑
Lumps / Masses	❑	❑
Respiratory		
Chronic Cough	❑	❑
Phlegm	❑	❑
Cough Up Blood	❑	❑
Short of Breath	❑	❑
Wheezing	❑	❑
Difficult Breathing	❑	❑
Chest Pain	❑	❑
Cardiovascular		
Murmur	❑	❑
Palpitation	❑	❑
Rapid Pulse	❑	❑
Swollen Ankles	❑	❑
Cold Hands/Feet	❑	❑
Varicose Veins	❑	❑
Blood Clots	❑	❑
Blue Hands/Feet	❑	❑
High BP	❑	❑
Low BP	❑	❑
Blood		
Anemia	❑	❑
Low Iron	❑	❑
Bruise Easily	❑	❑
Bleeding Disorder	❑	❑
Swollen Nodes	❑	❑
Tender Nodes	❑	❑
High Blood Sugar	❑	❑
Red Spots	❑	❑
Gastrointestinal		
Abdominal Pain	❑	❑
Nausea	❑	❑
Bloating	❑	❑
Belching	❑	❑
Heartburn	❑	❑
Indigestion	❑	❑
Constipation	❑	❑
Diarrhea	❑	❑
Undigested Food	❑	❑
Gas	❑	❑
Hemorrhoids	❑	❑
Poor Appetite	❑	❑
Food Intolerance	❑	❑
Bloody Stool	❑	❑
Black/ Tarry Stool	❑	❑
Diverticulitis	❑	❑
Vomiting	❑	❑
Vomiting Blood	❑	❑
Colitis/ Crohn's	❑	❑
Ulcers	❑	❑

Genitourinary	Now	Past
Urgency	❑	❑
Bed-Wetting	❑	❑
Incontinence	❑	❑
Frequent Voiding	❑	❑
Bladder Infection	❑	❑
Kidney Infection	❑	❑
Blood in Urine	❑	❑
Kidney Stones	❑	❑
Discharge	❑	❑
Painful Urination	❑	❑
Women Only		
Lumps in Breast	❑	❑
Hot Flashes	❑	❑
Menopause	❑	❑
Vaginal Discharge	❑	❑
Vaginal Itching	❑	❑
PMS	❑	❑
Irregular Periods	❑	❑
Spotting	❑	❑

Age at First Menses:_____
Length of Cycle:_____
Days of Flow:_____
Color: bright red/ dark red/ pale red/
Clots: ❑ yes ❑ no
Birth Control Type:_____
# of Pregnancies:_____
# of Births:___ Miscarriages:_____
Date of Last Period:_____
Are you pregnant? ❑ yes ❑ no
Are you trying to get pregnant? _____
Date of Last PAP:_____
❑normal ❑ abnormal
Date of Last Mammogram:_____
❑normal ❑ abnormal

Men Only	Now	Past
Testicular Mass	❑	❑

Date of Last Prostate Exam:_____
❑normal ❑ abnormal

Neurological	Now	Past
Seizures	❑	❑
Tremors	❑	❑
Loss of Sensation	❑	❑
Incoordination	❑	❑
Paralysis	❑	❑
Numbness	❑	❑
Tingling	❑	❑
Loss of Memory	❑	❑
Endocrine		
Weight Loss	❑	❑
Weight Gain	❑	❑
Heat Intolerance	❑	❑
Cold Intolerance	❑	❑
Hyperthyroidism	❑	❑
Hypothyroidism	❑	❑

Review of Health History (continued)

Name: _____

Please check the corresponding boxes if you have the condition now or have had it in the past.

Musculoskeletal	Now	Past
Muscle Pain	❑	❑
Muscle Cramps	❑	❑
Muscle Weakness	❑	❑
Muscle Twitching	❑	❑
Joint Stiffness	❑	❑
Arthritis	❑	❑
Type:_____		
Bursitis	❑	❑

Musculoskeletal	Now	Past
Low Back Pain	❑	❑
Middle Back Pain	❑	❑
Neck Pain	❑	❑
Hand Pain	❑	❑
Wrist Pain	❑	❑
Elbow Pain	❑	❑
Shoulder Pain	❑	❑
Foot Pain	❑	❑
Ankle Pain	❑	❑
Knee Pain	❑	❑
Hip Pain	❑	❑

Psychiatric	Now	Past
Hyperventilation	❑	❑
Eating Disorder	❑	❑
Depression	❑	❑
Irritability	❑	❑
Anxiety	❑	❑
Nervousness	❑	❑
Extreme Worry	❑	❑
Hallucinations	❑	❑
Alcoholism	❑	❑
Drug Addiction	❑	❑
Sexual Problems	❑	❑

Please check the corresponding box if you have had any of the following conditions.

❑ Measles	❑ Asthma	❑ Diabetes
❑ Mumps	❑ Pneumonia	❑ Appendicitis
❑ Chicken Pox	❑ Tuberculosis	❑ Multiple Sclerosis
❑ Cancer	❑ Liver Trouble	❑ Osteoporosis
❑ Tumor	❑ Hepatitis	❑ Epilepsy
❑ Angina	❑ Gall Stones	❑ Mental Illness
❑ Heart Disease	❑ Parasites	❑ Migraine
❑ Stroke	❑ Blood Disease	❑ STD
❑ Arteriosclerosis	❑ Gout	❑ Herpes
❑ High Cholesterol	❑ Goiter	❑ HIV / AIDS

Blood Type:
- ❑ A+
- ❑ A-
- ❑ B+
- ❑ B-
- ❑ AB+
- ❑ AB-
- ❑ 0+
- ❑ 0-

Immunizations/ Vaccinations:
- ❑ DPT
- ❑ MMR
- ❑ Smallpox
- ❑ Typhoid
- ❑ Meningitis
- ❑ Influenza
- ❑ Polio
- ❑ Hepatitis

Surgeries/ Injuries/ Serious Illnesses:

_____

_____

Medications/ Vitamins/ Supplements:

_____

_____

_____

Allergies:

_____

Social History: please check the box that most accurately represents you or fill in the blanks.

Mental Work: ❑ none ❑ light ❑ moderate ❑ heavy
Physical Work: ❑ none ❑ light ❑ moderate ❑ heavy
Exercise: - Days per week:_____
Types:_____

Sleep: hours per night:
Quality: ❑poor ❑fair ❑good ❑excellent
Difficulty Falling Asleep? ❑ yes ❑ no
Frequent Waking? ❑ yes ❑ no - if so what times?
Dream-Disturbed? ❑ yes ❑ no

Past Occupational History: _____

Please indicate usage per day or per week of the following:

Water: _____ glasses per day - ❑ room temp. ❑ cold
Coffee: _____cups per day/week (circle)
Tea: _____cups per day/week (circle)
Alcohol: _____drinks per day/week (circle)
Type: ❑ beer ❑ wine ❑ liquor

Soft Drinks: _____per day/week - ❑ regular ❑ diet
Juice: _____per day/week (circle)
Sweets: _____per day/week (circle)
Cigarettes: _____packs/day for _____ years

Please describe your energy levels:

How is your energy? (Please circle) Low - 0 1 2 3 4 5 6 7 8 9 10 - High
What time of day is your energy highest? ❑ 6am - 12pm ❑ 1 pm - 5pm ❑ 6pm - 12am
What time of day is your energy lowest? ❑ 6am - 12pm ❑ 1 pm - 5pm ❑ 6pm - 12am

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Patient Notification of Qualifications and Scope of Practice and Informed Consent

East Asian Medicine means a healthcare service using East Asian Medicine diagnosis and treatment to promote health and treat organic or functional disorders.

1. Qualifications for Jennifer L. Frey, L.Ac., EAMP, AP include the following education and license information:
   - Master's degree in Traditional Oriental Medicine
     Emperor's College - Santa Monica, CA (1/99 – 12/02)
   - WA ST Lic. # AC00002119, 1/14/03
   - FL ST Lic. # AP 2873
2. The scope of practice for an East Asian Medicine Practitioner in the state of Washington includes the following:
   - Acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians; and
   - Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians; Moxibustion; Acupressure; Cupping; Dermal friction technique; Infra-red; Sonopuncture; Laserpuncture; Point injection therapy (aquapuncture); and
   - Dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements; and
   - Breathing; Relaxation; East Asian exercise techniques; Qi gong; East Asian massage and Tui Na, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; and
   - Superficial heat and cold therapies.
3. Acupuncture is a generally safe method of treatment, but it may have side effects. These include, but are not limited to:
   - Pain following treatment; minor bruising, numbness or tingling near the needle sight and dizziness. Unusual and rare risks of acupuncture include fainting, spontaneous miscarriage, nerve damage and organ puncture (such as pneumothorax).
   - Burns and/or scarring are a potential risk of moxibustion and cupping.
   - Infection is a possible side-effect, however, this clinic uses disposable needles and maintains a clean and safe environment.
4. I do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I choose to rely on the practitioner to exercise judgment for the best course of treatment for my best interest, based on the facts known at the time. I understand that results are not guaranteed.
5. I agree to inform the East Asian Medicine Practitioner if I have a severe bleeding disorder, pace maker or any potentially serious conditions prior to any treatment.

I have read, or have had read to me, the above notification. By voluntarily signing below I agree to have the above named procedures. I have been informed of the benefits and risks of acupuncture and other procedures and have had the opportunity to ask questions. I intend for this consent form to cover the entire course of treatment for my present condition and/or for any future condition(s) for which I seek treatment.

Signature:_____ Date:_____

Cancellation Policy

We request that all cancellations be made with a minimum of 24-hour notice. Failure to provide 24-hour notice or a failure to show will result in your account being charged for the visitation at our standard fee. Thank you for your understanding.

Initial:_____ Date:_____

Financial Agreement

The patient or patient's representative shall pay Serenity Acupuncture – Jennifer Frey, LAc for services rendered in accordance with the regular rates and terms of the clinic. When this agreement is executed by the patient or patient's representative all shall be jointly and individually liable.

The patient or patient's representative hereby agrees to the above stated terms.

Signature:_____ Date:_____

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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.

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 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 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.

PATIENT SIGNATURE X
(Or Patient Representative) (date) (Indicate relationship if signing for patient)

AAC

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NOTICE OF PRIVACY POLICIES

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:

- Information we receive from you.
- Information we receive from healthcare providers.
- Information we receive from third party payers.

You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations. This office may use or disclose your *protected health information* when required by law. You may specifically authorize us to use *protected health information* for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosures will be made to any personal representative you choose to share your information with.

This office may send correspondence, such as, birthday cards, newsletters and appointment reminders, by phone calls, post cards, letters, emails or text.

Patient Rights:

Upon written request –

- You have the right to access, review or receive copies of your healthcare files.
- You have the right to receive a list of items this office has disclosed about your health information.
- You have the right to request that this office place additional restrictions on disclosure of your *protected health information.*
- You have the right to request that we amend your *protected health information*.
- You have a right to receive all notices in writing.

Complaints:
Complaints about your privacy rights or how your privacy is handled at this office can be submitted to our office directly. If you are not satisfied with how this office handles your complaint you may submit a formal complaint to:

DHHS (Office of Civil Rights)
200 Independence Avenue, S.W.
Room 509F B Building
Washington, D.C. 20201

I have read, understand and agree to the Notice of Privacy Policies from this office.
I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for healthcare operations. I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic. I understand that I have the right to request a restriction of how my protected health information is used. I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Print Name:_____

Signature:_____Date:_____