INTUITIVE

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Name ______________________________ Date ______________________

Address ______________________________ Birth date ____________ Age ____________

____

Phone ______________________________ Email ______________________

Gender ______________________________ Birthplace ______________________

Education ______________________________ Occupation ______________________

Personal & Family History - please complete all that apply. If you have allergies, for example, please indicate what you are allergic to in the space provided.

	You	**Mother**	**Father**	**Brother/Sister**
Allergies (please indicate seasonal +/or food)				
Blood disorder				
Diabetes				
Cancer/tumors				
Seizures				
High or low Blood Pressure (please indicate high or low)				
Kidney/Bladder issues				
Stomach/Intestinal issues				
Alcohol or drug abuse				
Heart disorder				
Stroke				
Other illness or ailment(s)				
Age of death				

Reason that you are seeking support today:

____

Primary Symptoms ____

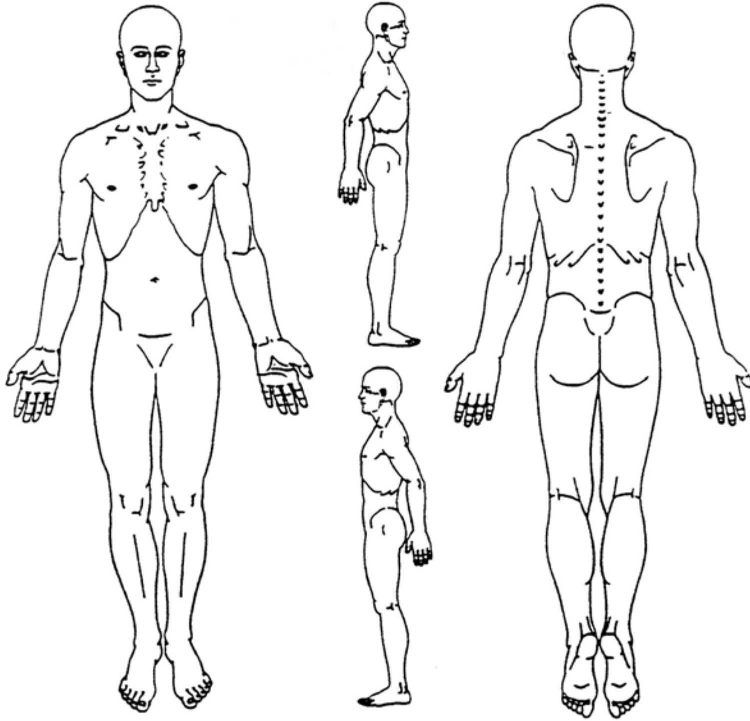
____

S]↑*\~↑ History

When and how did your symptoms begin: ____

____

Overall are your symptoms: ☐ Improving ☐ Remaining the same ☐ Worsening



Mark the location of your symptoms:

Pain

//// Sharp

△ Aching

↓↓↓ Radiating

*** Numbness/tingling/burning

Swelling

Pain Intensity: (rate pain from 0 to 10)

No pain Worst Pain

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

List and date any major surgeries, accidents, or traumas:

1. _________________________________ Onset? ____________ Severity? (1-10) _______
2. _________________________________ Onset? ____________ Severity? (1-10) _______
3. _________________________________ Onset? ____________ Severity? (1-10) _______
4. _________________________________ Onset? ____________ Severity? (1-10) _______

ALLERGIES

List any known allergies and describe your reaction:

1. ________________________________ 4. ________________________________
2. ________________________________ 5. ________________________________
3. ________________________________ 6. ________________________________

REVIEW OF SYSTEMS

Please check any conditions you are currently experiencing or have experienced in the past.

Gastrointestinal

- ☐ Nausea
- ☐ Pain/Cramps
- ☐ Excess Gas
- ☐ Vomiting
- ☐ Excess belching
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Black stools
- ☐ Sensitive abdomen
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Blood in stools
- ☐ Bad breath
- ☐ Peptic ulcers
- ☐ Rectal bleeding
- ☐ Gastritis

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Blood clots
- ☐ Dizziness
- ☐ Fainting
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Cold hands/feet
- ☐ Difficulty breathing
- ☐ Irregular heartbeat
- ☐ Hand/foot swelling

Respiratory

- ☐ Cough
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Asthma
- ☐ Bronchitis
- ☐ Tightness in chest
- ☐ Phlegm production
- ☐ Breathing difficulties when lying down

Genito-Urinary

- ☐ Pain on urination
- ☐ Incontinence
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Impotency
- ☐ Blood in urine
- ☐ Waking to urinate

*If waking to urinate at night, how many times per night (on average)? ________

Neuropsychological

- ☐ Seizures
- ☐ Depression
- ☐ Area of numbness
- ☐ Anxiety
- ☐ Poor memory
- ☐ Mood swings
- ☐ Concussion
- ☐ Easily stressed

*Have you been treated for emotional difficulties? ☐ Yes ☐ No If so, when? ___________________

Head, Eyes, Ears, Nose, Throat

- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Dry mouth
- ☐ Dry throat
- ☐ Excess saliva
- ☐ Gum problems
- ☐ Frequent sore throat
- ☐ Lip/Tongue Sores
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Excess mucus
- ☐ Migraines
- ☐ Facial pain
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Blurry vision
- ☐ Cataracts
- ☐ Spots in eyes
- ☐ Eye strain
- ☐ Night blindness
- ☐ Glasses/Contacts
- ☐ Eye pain
- ☐ Poor vision
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Eye strains

Skin and Hair

- ☐ Rashes
- ☐ Eczema
- ☐ Ulcerations
- ☐ Acne
- ☐ Hives
- ☐ Dandruff
- ☐ Itching
- ☐ Loss of hair

*Change in hair/skin texture? ☐ Yes ☐ No

*Other hair/skin problems: ____

REVIEW OF SYSTEMS - CONTINUED

Sweat

☐ Easily perspire ☐ Rarely perspire ☐ Night sweats

Temperature

☐ Heat intolerance ☐ Cold intolerance ☐ Alternating hot/cold

*If you experience feelings of heat, where is it located? ______________________

*If you experience feelings of coldness, where is it located? ___________________

Sleep

☐ Cannot fall asleep ☐ Wake too early ☐ Tossing/turning ☐ Tired upon waking

☐ Wake up easily ☐ Excessive sleep ☐ Snoring ☐ Lots of dreams

*How many times do you wake up during the night (on average)? _____

Appetite

☐ Strong ☐ Average ☐ Low ☐ Snacks :)

Please fill this out according to your current lifestyle:

	Never	Sometimes	Often
Fruits and veggies			
Meat			
Dairy			
Fast food			
Soda/Caffeine			
Sugar			
Gluten			
Cigarettes			
Alcohol			
Marijuana			
Other recreational drugs			

Pregnancy and Gynecology (if applicable)

Are you pregnant? ☐ Yes ☐ No If Yes, how many months? ___________________________________

Number of children: _____ Ages: ____

Number of pregnancies: ____ Number of live births: ____ Premature births: ____ Miscarriages: _____

Last PAP: _____ Age at first period: ____ Period duration (days): ____ Last period: ____

Flow: ☐ Heavy ☐ Light ☐ Regular ☐ Irregular

Menopausal Status: ☐ Pre-menopausal ☐ Post-menopausal

Do you experience clotting and/or vaginal discharge? ☐ Yes ☐ No

If yes, how much and how often? ____

Do you experience vaginal sores? ☐ Yes ☐ No Breast lumps? ☐ Yes ☐ No

ACUPUNCTURE INFORMED CONSENT

I, _____________________________ hereby request and consent to acupuncture treatment(s) and other procedures and modalities associated with Traditional Chinese Medicine (TCM) by Britta Van Dun, L.Ac. I have discussed the nature and purpose of my treatment, and understand that methods of treatment may include, but are not limited to acupuncture, nutritional counseling, moxibustion, cupping, Gua Sha, Tuina (Chinese Medical massage) and Qigong (energy work). I understand that the diagnosis given to me conforms to the principles of (TCM) and in no way purports to replace allopathic (Western) medical evaluation, diagnosis or treatment.

I have provided a full history and description of complaints and health status which is complete and accurate. I understand that the need for communication with all of my health care providers regarding my health status is ongoing and necessary. I understand that no guarantee has been made concerning the use and effects of TCM. I understand that I may stop treatment at any time. I will notify Britta Van Dun if I am or become pregnant.

I have been informed that acupuncture is a generally safe method of treatment that utilizes sterile needles and is done in a clean, safe environment. But, as with all medical procedures, TCM treatment may have side effects including: bruising, numbness or tingling, minor bleeding, broken needle, dizziness and fainting. Some very rare risks of acupuncture include pneumothorax and infection. Burns and/or scarring are a potential risk of indirect moxibustion. Rarely, bodywork may cause a temporary increase of symptoms. I understand that while this form describes the major risks of treatment, other side effects may occur.

Homeopathic remedies that have been recommended are traditionally considered safe in the practice of Holistic Energy Medicine, although some may cause aggravations. I will immediately notify Britta Van Dun of any unanticipated or unpleasant affects associated with the consumption of any suggested remedy or supplement. I understand that Britta is not a licensed Homeopath.

If I am being treated for fertility, pregnancy or labor, I understand this procedure and specifically waive my right to any legal claim that may arise through this treatment. I agree to hold Britta Van Dun, L.Ac. harmless for any and all complications that may occur to me or my child as a result of acupuncture labor induction.

As indicated on her website, Britta Van Dun, LAc has a 48 hour cancellation window. This is to respect the time of the practitioner and give other clients an opportunity to schedule. Cancellations made 24 hours or less before an appointment, along with no-shows will incur a charge of $75. No shows will be charged the full session amount ($125).

By signing below I show that I have read this consent to treatment and understand the risks and benefits of acupuncture and other procedures. I understand the 48 hour cancellation policy. I intend this consent form to cover the entire course of treatment for my present and any future conditions for which I seek treatment.

_____________________________ _____________________________

Name (print + sign) **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.

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 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.

Name:____Signature: _________________________Date:_______________

Provider Signature: ___________________________________Date: ____________