

**Bowen Chiropractic and Wellness Center**

794 South Highway 89 Chino Valley, Arizona \* 9286367682 \* www.bowenchiro.com

**NEW PATIENT INTAKE FORM**

Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Name** \_\_\_\_\_ **SS#** \_\_\_\_\_ **Birthdate** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
**Address** \_\_\_\_\_ **Marital Status**  M  F **Age** \_\_\_\_\_  
**Ht** \_\_\_\_\_ **Wt** \_\_\_\_\_

**Email** \_\_\_\_\_ **Occupation** \_\_\_\_\_  
**City, State, Zip** \_\_\_\_\_ **Work** \_\_\_\_\_ **Cell** \_\_\_\_\_  
**Home Phone** \_\_\_\_\_  
**Emergency Contact's Name & Phone** \_\_\_\_\_  
**Referred by** \_\_\_\_\_  
**Reason for visit today** \_\_\_\_\_ **Have you had acupuncture before?**  Yes  No **Chinese herbal medicine?**  Yes  No

**How long have you had this condition?** \_\_\_\_\_  
**Is it getting worse?** \_\_\_\_\_ **Does it bother your**  Sleep  Work  Other (specify) \_\_\_\_\_

**What seemed to be the initial cause?** \_\_\_\_\_  
**What seems to make it better?** \_\_\_\_\_  
**What seems to make it worse?** \_\_\_\_\_  
**Are you under the care of a physician now?**  Yes  No **If yes, for what?** \_\_\_\_\_  
**Physician's name** \_\_\_\_\_ **Physician's phone** \_\_\_\_\_

**Other concurrent therapies**

**Health Insurance Info:**

**Insurance Co. Name** \_\_\_\_\_ **Policy #** \_\_\_\_\_  
**Address** \_\_\_\_\_ **Phone** \_\_\_\_\_  
**City, State, Zip** \_\_\_\_\_

**Medicare Info:**

**Insurance Co. Name** \_\_\_\_\_ **Policy #** \_\_\_\_\_  
**Address** \_\_\_\_\_ **Phone** \_\_\_\_\_  
**City, State, Zip** \_\_\_\_\_

**Family Medical History**

Allergies (list) \_\_\_\_\_  Arteriosclerosis \_\_\_\_\_  Cancer (type) \_\_\_\_\_  Diabetes (Type: \_\_\_\_\_)  Seizures \_\_\_\_\_  
 Asthma \_\_\_\_\_  Emphysema \_\_\_\_\_  Depression \_\_\_\_\_  Heart disease \_\_\_\_\_  Stroke \_\_\_\_\_  
 Alcoholism \_\_\_\_\_  Gout \_\_\_\_\_  High blood pressure \_\_\_\_\_

**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.)

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Diabetes (Type: _____)	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Surgery (list) _____	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Mumps	_____	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Allergies	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pacemaker (Date: _____)	_____	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Goiter	<input type="checkbox"/> Pleurisy	_____	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Gout	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Thyroid disorders	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Polio	<input type="checkbox"/> Major trauma	<input type="checkbox"/> Other (Specify) _____
<input type="checkbox"/> Birth trauma (your own birth)	<input type="checkbox"/> Hepatitis (Type: _____)	<input type="checkbox"/> Rheumatic fever	(Car, fall, etc--list) _____	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes (Type: _____)	<input type="checkbox"/> Scarlet fever	_____	_____
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Seizures	_____	_____
	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke	_____	_____

**Your Diet**

**Appetite**  Low  High **Coffee/Tea**  Soft Drinks/Fruit Juices **Protein Intake**  Low  High **Artificial Sweeteners**  Sugar  Salty foods **Thirst for water:** # glasses per day: \_\_\_\_\_

**Average Daily Menu**

<b>Morning</b>	<b>Snack</b>	<b>Noon</b>	<b>Snack</b>	<b>Evening</b>	<b>Snack</b>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**Pharmaceuticals taken in the last 2 months:** \_\_\_\_\_  
**Vitamins/supplements taken in the last 2 months:** \_\_\_\_\_

**Practitioner Use Only**

## Your Lifestyle

- |                                  |                                    |   |                         |                 |
|----------------------------------|------------------------------------|---|-------------------------|-----------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Stress               | <b>Regular Exercise</b> | Frequency _____ |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Drugs     | <input type="checkbox"/> Occupational hazards | Type _____              | Frequency _____ |
|                                  |                                    |   | Type _____              | Frequency _____ |

## General Symptoms

- |  |  |  |   |  |
|--|--|--|---|--|
| <input type="checkbox"/> Poor appetite             | <input type="checkbox"/> Poor sleep            | <input type="checkbox"/> Bodily heaviness    | <input type="checkbox"/> Chills               | <input type="checkbox"/> Bleed or bruise easily          |
| <input type="checkbox"/> Heavy appetite            | <input type="checkbox"/> Heavy sleep           | <input type="checkbox"/> Cold hands or feet  | <input type="checkbox"/> Night sweats         | <input type="checkbox"/> Peculiar taste (Describe) _____ |
| <input type="checkbox"/> Strongly like cold drinks | <input type="checkbox"/> Dream-disturbed sleep | <input type="checkbox"/> Poor circulation    | <input type="checkbox"/> Sweat easily         | _____  |
| <input type="checkbox"/> Strongly like hot drinks  | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Muscle cramps        | _____  |
| <input type="checkbox"/> Recent weight loss/gain   | <input type="checkbox"/> Lack of strength      | <input type="checkbox"/> Fever               | <input type="checkbox"/> Vertigo or dizziness | _____  |

## Head, Eyes, Ears, Nose, Throat

- |  |   |  |   |  |
|--|---|--|---|--|
| <input type="checkbox"/> Glasses (What age: _____) | <input type="checkbox"/> Night blindness      | <input type="checkbox"/> Gum problems            | <input type="checkbox"/> Recurrent sore throat          | <input type="checkbox"/> Headaches                         |
| <input type="checkbox"/> Eye strain                | <input type="checkbox"/> Myopia or Presbyopia | <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Swollen glands                 | <input type="checkbox"/> Migraines                         |
| <input type="checkbox"/> Eye pain                  | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Dry mouth               | <input type="checkbox"/> Lumps in throat                | <input type="checkbox"/> Concussions                       |
| <input type="checkbox"/> Red eyes                  | <input type="checkbox"/> Cataracts            | <input type="checkbox"/> Excessive saliva        | <input type="checkbox"/> Enlarged thyroid               | <input type="checkbox"/> Other head or neck problems _____ |
| <input type="checkbox"/> Itchy eyes                | <input type="checkbox"/> Teeth problems       | <input type="checkbox"/> Sinus problems          | <input type="checkbox"/> Nosebleeds                     | _____  |
| <input type="checkbox"/> Spots in eyes             | <input type="checkbox"/> Grinding teeth       | <input type="checkbox"/> Excessive phlegm        | <input type="checkbox"/> Ringing in ears (High or Low?) | _____  |
| <input type="checkbox"/> Poor vision               | <input type="checkbox"/> TMJ                  | Color: _____                                     | <input type="checkbox"/> Poor hearing                   | _____  |
| <input type="checkbox"/> Blurred vision            | <input type="checkbox"/> Facial pain          |  | <input type="checkbox"/> Earaches                       | _____  |

## Respiratory

- |   |  |                                |                       |  |
|---|--|--------------------------------|-----------------------|--|
| <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> Tight chest                       | <input type="checkbox"/> Cough | Color of phlegm _____ | <input type="checkbox"/> Coughing up blood |
| <input type="checkbox"/> Shortness of breath                  | <input type="checkbox"/> Asthma/wheezing                   | Wet or Dry? _____              |                       | <input type="checkbox"/> Pneumonia         |
|   | <input type="checkbox"/> Difficult inhalation? exhalation? | Thick or thin? _____           |                       |  |

## Cardiovascular

- |  |   |   |   |  |
|--|---|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain           | <input type="checkbox"/> Tachycardia        | <input type="checkbox"/> Phlebitis           |
| <input type="checkbox"/> Blood clots         | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Irregular heartbeat |

## Gastrointestinal

- |   |   |  |                        |                    |
|---|---|--|------------------------|--------------------|
| <input type="checkbox"/> Nausea             | <input type="checkbox"/> Diarrhea         | <input type="checkbox"/> Intestinal pain or cramping | Bowel movements: _____ |                    |
| <input type="checkbox"/> Vomiting           | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Burning anus                | Frequency _____        | Texture/form _____ |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Black stools     | <input type="checkbox"/> Rectal pain                 | Color _____            | Odor _____         |
| <input type="checkbox"/> Gas                | <input type="checkbox"/> Bloody stools    | <input type="checkbox"/> Anal fissures               |                        |                    |
| <input type="checkbox"/> Hiccup             | <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Laxative use                |                        |                    |
| <input type="checkbox"/> Bloating           | <input type="checkbox"/> Hemorrhoid       | What kind? _____                                     |                        |                    |
| <input type="checkbox"/> Bad breath         | <input type="checkbox"/> Itchy anus       | How often? _____                                     |                        |                    |

## Musculoskeletal

- |   |  |                                     |  |                        |
|---|--|-------------------------------------|--|------------------------|
| <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Limited range of motion | Other (Describe) _____ |
| <input type="checkbox"/> Muscle pain        | <input type="checkbox"/> Low back pain   | <input type="checkbox"/> Rib pain   | <input type="checkbox"/> Limited use             | _____                  |

## Skin and Hair

- |                                      |                                    |                                    |  |                                   |
|--------------------------------------|------------------------------------|------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Rashes      | <input type="checkbox"/> Eczema    | <input type="checkbox"/> Dandruff  | <input type="checkbox"/> Change in hair/skin texture | Other hair or skin problems _____ |
| <input type="checkbox"/> Hives       | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Itching   | <input type="checkbox"/> Fungal infections           | _____                             |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Acne      | <input type="checkbox"/> Hair loss |  | _____                             |

## Neuropsychological

- |                                   |                                      |  |   |                       |
|-----------------------------------|--------------------------------------|--|---|-----------------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Irritability    | <input type="checkbox"/> Considered/attempted suicide | Other (Specify) _____ |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Depression  | <input type="checkbox"/> Easily stressed | <input type="checkbox"/> Seeing a therapist           | _____                 |
| <input type="checkbox"/> Tics     | <input type="checkbox"/> Anxiety     | <input type="checkbox"/> Abuse survivor  |   | _____                 |

## Genitourinary

- |   |   |   |   |  |
|---|---|---|---|--|
| <input type="checkbox"/> Pain on urination  | <input type="checkbox"/> Blood in urine       | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Impotence             |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Bedwetting       | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Urgent urination   | <input type="checkbox"/> Incomplete urination | <input type="checkbox"/> Wake to urinate  | <input type="checkbox"/> Kidney stone     | <input type="checkbox"/> Nocturnal emission    |

## Gynecology

- |   |   |  |   |                              |
|---|---|--|---|------------------------------|
| <input type="checkbox"/> Age menses began _____ | <input type="checkbox"/> Duration of flow _____ | <input type="checkbox"/> Vaginal discharge (color) _____ | <input type="checkbox"/> Breast lumps _____ | Date of last PAP _____       |
| Length of cycle (day 1 to day 1) _____          | <input type="checkbox"/> Irregular periods      | <input type="checkbox"/> Vaginal sores                   | # Pregnancies _____                         |                              |
|   | <input type="checkbox"/> Painful periods        | <input type="checkbox"/> Vaginal odor                    | # Live births _____                         |                              |
|   | <input type="checkbox"/> PMS                    | <input type="checkbox"/> Clots                           | # Premature births _____                    | Date last period began _____ |
|   |   |  | Age at menopause _____                      |                              |

## Other

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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 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.**

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

OFFICE SIGNATURE **X** (Date)

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, 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.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE

X

(Or Patient Representative)

(Indicate relationship if signing for patient)

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