

# Patient History Form



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Office Use ONLY

Patient ID: \_\_\_\_\_

Chart Location: \_\_\_\_\_

## General Information

Date: \_\_\_/\_\_\_/\_\_\_ Name: \_\_\_\_\_ Sex:  M  F

First M. Last

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

(\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_  
home work mobile

DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Birth Place: \_\_\_\_\_ Height: \_\_\_\_\_' \_\_\_\_\_" Weight: \_\_\_\_\_ lbs.

### Marital Status:

Single  Married  Divorced  Widowed  Living with Social Security#: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

## Provider Information

Primary Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

## Focus Information

Referred by: \_\_\_\_\_

Reason for visit today: \_\_\_\_\_

Other problems: \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Have you ever experienced this before?  Yes  No

What seemed to be the initial cause? \_\_\_\_\_

What seems to make it better? \_\_\_\_\_

What seems to make it worse? \_\_\_\_\_

Does it bother you when you:  Sleep  Standing  Sexually  Other  
 Work  Emotional  Recreation \_\_\_\_\_  
 Walking  Relationships  Bending \_\_\_\_\_  
 Sitting  Social Life  Stretching

Have you done anything for this condition  Yes  No (explain) \_\_\_\_\_

Are you interested in:  Pain Relief  Performance Care  Maintenance Care  Other  
 Preventative Care  Holistic Health  Stress Relief \_\_\_\_\_  
 Nutrition  Qi Gong  Herbal Therapy \_\_\_\_\_

What are your health goals? \_\_\_\_\_

List any past or future surgeries \_\_\_\_\_

List any significant trauma and when it occurred (auto accident, fall, emotional, sexual, etc.) \_\_\_\_\_

List any activity or sport activities you have been or currently involved in: \_\_\_\_\_

### Signs / Symptoms

Please indicate if you have experienced any of the following over the past year. Select all that apply.

- |  |  |  |  |  |
|--|--|--|--|--|
| <input type="checkbox"/> Abdominal pain/distention | <input type="checkbox"/> Coughing Blood          | <input type="checkbox"/> Hemorrhoids             | <input type="checkbox"/> Mucous in stools      | <input type="checkbox"/> Seizures              |
| <input type="checkbox"/> Abuse survivor            | <input type="checkbox"/> Dark Stools             | <input type="checkbox"/> Heart palpitations      | <input type="checkbox"/> Muscle cramps/pain    | <input type="checkbox"/> Seeing a therapist    |
| <input type="checkbox"/> Acid regurgitation        | <input type="checkbox"/> Decreased libido        | <input type="checkbox"/> Hiccups                 | <input type="checkbox"/> Nasal congestion      | <input type="checkbox"/> Short temper          |
| <input type="checkbox"/> Acne                      | <input type="checkbox"/> Depression              | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Neck/shoulder pain    | <input type="checkbox"/> Shortness of breath   |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Dizziness/vertigo       | <input type="checkbox"/> Impotence               | <input type="checkbox"/> Night sweats          | <input type="checkbox"/> Sinus pressure        |
| <input type="checkbox"/> Bad breath                | <input type="checkbox"/> Dry throat/mouth        | <input type="checkbox"/> Increased libido        | <input type="checkbox"/> Nocturnal emission    | <input type="checkbox"/> Skin fungal infection |
| <input type="checkbox"/> Blood in stools           | <input type="checkbox"/> Diarrhea                | <input type="checkbox"/> Indigestion             | <input type="checkbox"/> Nose bleeds           | <input type="checkbox"/> Spots in eyes         |
| <input type="checkbox"/> Blood in urine            | <input type="checkbox"/> Ear aches               | <input type="checkbox"/> Intestinal pain/cramps  | <input type="checkbox"/> Numbness              | <input type="checkbox"/> Sweat easily          |
| <input type="checkbox"/> Blurry vision             | <input type="checkbox"/> Enlarged thyroid        | <input type="checkbox"/> Irritable               | <input type="checkbox"/> Odorous stools        | <input type="checkbox"/> Sore throat           |
| <input type="checkbox"/> Breast lump/pain          | <input type="checkbox"/> Eye pain/strain/tension | <input type="checkbox"/> Itchy eyes              | <input type="checkbox"/> Pain upon urination   | <input type="checkbox"/> Sudden energy drop    |
| <input type="checkbox"/> Bruise easily             | <input type="checkbox"/> Excessive phlegm        | <input type="checkbox"/> Itchy skin              | <input type="checkbox"/> Peculiar tastes       | <input type="checkbox"/> Swollen glands        |
| <input type="checkbox"/> Chest pains               | <input type="checkbox"/> Excessive saliva        | <input type="checkbox"/> Joint pain              | <input type="checkbox"/> Poor appetite         | <input type="checkbox"/> Teeth/gum problems    |
| <input type="checkbox"/> Chills                    | <input type="checkbox"/> Fatigue                 | <input type="checkbox"/> Kidney stones           | <input type="checkbox"/> Poor circulation      | <input type="checkbox"/> Ulcerations           |
| <input type="checkbox"/> Cold hands/feet           | <input type="checkbox"/> Fever                   | <input type="checkbox"/> Laxative use            | <input type="checkbox"/> Poor memory           | <input type="checkbox"/> Upper back pain       |
| <input type="checkbox"/> Concussion                | <input type="checkbox"/> Frequent urination      | <input type="checkbox"/> Limited range of motion | <input type="checkbox"/> Poor sleep            | <input type="checkbox"/> Urgent urination      |
| <input type="checkbox"/> Confusion                 | <input type="checkbox"/> Gas/belching            | <input type="checkbox"/> Loss of hair            | <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Vomiting              |
| <input type="checkbox"/> Constipation              | <input type="checkbox"/> Grinding teeth          | <input type="checkbox"/> Low back pain           | <input type="checkbox"/> Psoriasis             | <input type="checkbox"/> Wake to urinate       |
| <input type="checkbox"/> Cough                     | <input type="checkbox"/> Headache                | <input type="checkbox"/> Migraines               | <input type="checkbox"/> Rash                  | <input type="checkbox"/> Weight loss/gain      |
|  |  | <input type="checkbox"/> Mouth sores             | <input type="checkbox"/> Redness of eyes       | <input type="checkbox"/> Wheezing              |

### Female Concerns

Date of last menstruation: \_\_\_\_/\_\_\_\_/\_\_\_\_ Is your cycle regular?  Yes  No Is your cycle painful?  Yes  No

Have you ever been pregnant?  Yes  No Are you currently using birth control?  Yes  No If so, how long? \_\_\_\_\_

Check all that apply:  PMS  Clotting  Vaginal sores  Vaginal pain  Discharge

### Medical History

Do you have allergies?  Yes  No If so, what? \_\_\_\_\_

Do you take medications?  Yes  No If so, what types and how often? \_\_\_\_\_

Do you take supplements?  Yes  No If so, what types and how often? \_\_\_\_\_

Please indicate if you or any family member have or had any of the following conditions (Key: I-Myself; F-Father; M-Mother; S-Siblings)

- |                        |                         |                     |                                   |                              |
|------------------------|-------------------------|---------------------|-----------------------------------|------------------------------|
| Pneumonia - I F M S    | Drug reaction - I F M S | Seizures - I F M S  | Gonorrhea/Herpes - I F M S        | Cancer - I F M S             |
| Tuberculosis - I F M S | Heart attack - I F M S  | Jaundice - I F M S  | Blood transfusion - I F M S       | Mental illness - I F M S     |
| Hepatitis - I F M S    | HIV/Aids - I F M S      | Parasites - I F M S | High/low blood pressure - I F M S | Hypo/hyper thyroid - I F M S |
| Diabetes - I F M S     | Anemia - I F M S        | Measles - I F M S   | Premature graying - I F M S       | Heart disease - I F M S      |
| Arthritis - I F M S    | Mumps - I F M S         | Epilepsy - I F M S  | Mental breakdown - I F M S        | Kidney stones - I F M S      |
| Obesity - I F M S      | Syphilis - I F M S      | Gout - I F M S      | Multiple Sclerosis - I F M S      |                              |

## Personal Lifestyle Habits

(how much, how many, or how often)

Cigarettes (per day) \_\_\_\_\_ Coffee/Tea (per day) \_\_\_\_\_ Alcohol (drinks per week) \_\_\_\_\_

Vitamins & herbs \_\_\_\_\_ Dietary restrictions \_\_\_\_\_ Food cravings \_\_\_\_\_

**Diet:** *What might you eat on a typical day?*

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Do you exercise?  Yes  No If yes, how many times a week and how long? \_\_\_\_\_

What non-work activities do you enjoy? (reading, TV, meditation, music, etc.) \_\_\_\_\_

When do you feel at your best during the day? (energy) \_\_\_\_\_

Do you have a daily high point?  Yes  No If so, when? \_\_\_\_\_ Do you sleep well?  Yes  No

Do you have a daily low point?  Yes  No If so, when? \_\_\_\_\_ Do you dream?  Yes  No

## Pain Identification

*Please circle one that best describes your condition.*

**Pain intensity levels:** (please indicate which best describes your level of pain)

No pain      Moderate      Intense      Severe

**Sleeping:**

No problems      Mildly disturbed      Greatly disturbed      Cannot Sleep

**Work - Can do:**

Usual work      25% of work      50% of work      No work

**Frequency of Pain:**

25% of time      50% of time      75% of time      100% of time

**Travel: (ie driving in a car)**

No problems      Moderate Pain      Severe Pain

**Recreation - Can do:**

All activities      Some activities      No activities

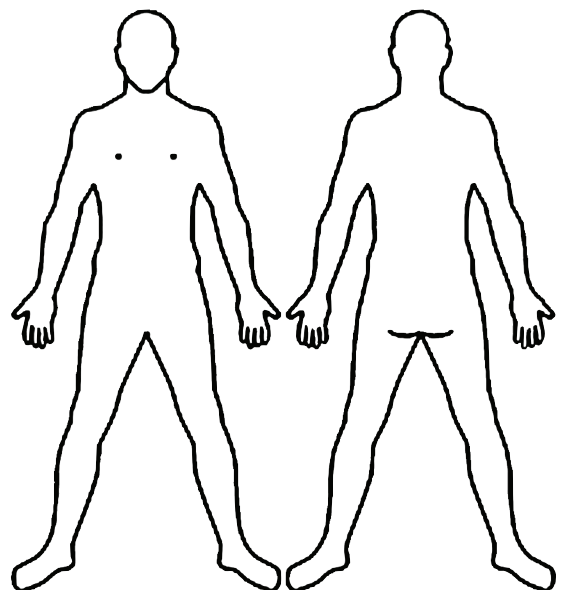
**Walking - Can do:**

Any distance      Pain after 1/2 mile      Cannot Walk

**Sitting:**

No Pain      Some pain      Cannot sit

*Please identify areas of pain, tension, tightness or discomfort on the diagram below.*



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, 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 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.

**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	<b>X</b>	(Date)
(Or Patient Representative)		(Indicate relationship if signing for patient)
OFFICE SIGNATURE	<b>X</b>	(Date)

ALSO SIGN THE INFORMED CONSENT ON NEXT PAGE

## 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 Free Spirit Acupuncture and Wellness Center LLC (Shawn Kissick) 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 at Free Spirit Acupuncture and Wellness Center LLC, including those working at the Beaver facility (320 College Avenue, Beaver PA, 15009) 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 be 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 effect 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.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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.

PATIENT SIGNATURE	<b>X</b>	(Date)
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(Or Patient Representative)

(Indicate relationship if signing for patient)

**ALSO SIGN THE ARBITRATION AGREEMENT ON PREVIOUS PAGE**