Polyvagal Acupuncture®

Name: _____ Date: _____

Home Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Phone: _____ SS#: _____

Occupation: _____

How do you like to be addressed: _____ Preferred Pronouns: _____

What is your Chief Complaint: (List all): _____

Please rate pain levels (1-5):

Sex: M ☐ F ☐ Height _____ Weight _____ Birthdate _____ Age _____

Marital Status Married ❑ Single ❑ Divorced ❑ Widowed ❑ Life Partner ❑

Have you received acupuncture before? Y ☐ N ☐ With whom: _____

PLEASE INDICATE ANY SIGNIFICANT MEDICAL HISTORY IN YOU OR A BLOOD RELATIVE:

	You	Relative	Date		You	Relative	Date
Cancer	❑	❑	❑	Diabetes	❑	❑	❑
Hepatitis	❑	❑	❑	Heart Disease	❑	❑	❑
Seizures	❑	❑	❑	High Blood Pressure	❑	❑	❑
Rheumatic Fever	❑	❑	❑	Emotional/Depression	❑	❑	❑
Infectious Diseases	❑	❑	❑	TB	❑	❑	❑

STDs: Gonorrhea ❑ Syphilis ❑ HIV/Aids ❑ HPV ❑ Herpes ❑

PLEASE LIST ANY MEDICATIONS/SUPPLEMENTS THAT YOU ARE TAKING (Continue on back if necessary):

Medicine	Dosage	Reason	How Long	Prescribed by	Date of last check-up

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Please indicate the use and frequency of the following:

	Yes	No	How Often		Yes	No	How Often
Coffee	❑	❑	_____	Tobacco	❑	❑	_____
Recreation Drugs	❑	❑	_____	Alcohol	❑	❑	_____
Soda Pop	❑	❑	_____	Water Intake	❑	❑	

For Women

Age of 1st period (menarche):	Are you pregnant?		# of pregnancies:
Age of last period (menopause):	# of live births:	# of abortions:	# of miscarriages:
Number of days between periods:	Date of last GYN exam:		Pap smear:
Number of days of flow:	Mammogram:		Bone density scan:
Color of flow:	Results:		
Clots?			

Average number of pads you use per day? 1st day____2nd day____3rd day____ 4th day____ +days____

Have you been diagnosed with: ❑ Fibroids ❑ Fibrocystic breasts ❑ Endometriosis ❑ Ovarian Cysts ❑ PID ❑ Other_____

Menstrual Pain and location:

Nature of pain:

☐ Cramping	☐ Aching	Hormonal Symptoms:	
☐ Burning	☐ Consistent	☐ Hot Flashes	☐ Weight Gain
☐ Dull	☐ Intermittent	☐ Irritability	☐ Bloating
☐ Bearing down sensation	☐ Stabbing		

For Men

☐ Prostate Issues	☐ Pelvic Pain
☐ Low Testosterone	☐ Testicular Pain
☐ Erectile Dysfunction	☐ Prostate Surgery
☐ Urinary Problems	☐ Vasectomy
☐ Hair Loss	☐ Hernia Repair
☐ Infertility	☐ Testicular Surgery

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General Symptoms

Digestive Symptoms

- ☐ Lack of appetite
- ☐ Excessive appetite
- ☐ Loose stool or diarrhea
- ☐ Digestive problems
- ☐ Indigestion
- ☐ Jaundice (yellowish eyes or skin)
- ☐ GB removal
- ☐ Vomiting
- ☐ Belching, burping
- ☐ Heartburn/reflux
- ☐ Feeling the retention of food in the stomach
- ☐ Nausea or vomiting
- ☐ Colitis or diverticulitis
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Blood in stool
- ☐ Black tarry stool
- ☐ Light-colored stool
- ☐ Loose stools or dumping syndrome
- ☐ _____

Urinary Symptoms

- ☐ Urinary problems
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Prostate Issues
- ☐ ED or Low T
- ☐ Decreased sex drive
- ☐ Increased or decreased libido
- ☐ Retention of urine
- ☐ Pain or coldness in the genital area
- ☐ Kidney stones

Hormonal & Endocrine Symptoms

- ☐ Type 2 Diabetes
- ☐ High cholesterol levels
- ☐ Fatty Liver Disease
- ☐ Difficulty digesting oily foods
- ☐ Gall stones
- ☐ Menopausal Symptoms
- ☐ Leaky Gut
- ☐ Autoimmune disease
- ☐ Food allergies or gluten sensitivity

Neurological & Mental Health Symptoms

- ☐ Insomnia, difficulty sleeping
- ☐ Nightmares
- ☐ Mentally restless
- ☐ Laughing for no apparent reason
- ☐ Easily angered or agitated
- ☐ Difficulty in making plans or decisions
- ☐ Dizziness
- ☐ Tendency to faint easily
- ☐ Shortness of breath
- ☐ Decreased sense of smell
- ☐ Feeling of claustrophobia
- ☐ Anxiety or nervousness
- ☐ Trauma
- ☐ Depression or sadness
- ☐ Stress
- ☐ Fatigue
- ☐ Spasms or twitching of muscles
- ☐ Childhood or Sexual abuse
- ☐ Headaches
- ☐ Difficulty in making plans or decisions

Cardiovascular Symptoms

- ☐ Heart palpitations
- ☐ Angina pains
- ☐ Chest pain
- ☐ Cold hands and feet
- ☐ Increased or decreased blood pressure

Skin & Appearance Symptoms

- ☐ Eczema
- ☐ Easily bruised
- ☐ Hair loss
- ☐ Skin Cancer

Musculoskeletal Symptoms

- ☐ Back pain
- ☐ Sciatic pain
- ☐ Knee problems
- ☐ Low back pain
- ☐ Muscle or joint pain

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Respiratory Symptoms	General & Miscellaneous Symptoms
☐ Cough	☐ Easily bruised
☐ Asthma	☐ Soft or brittle nails
☐ Hay fever	☐ Difficulty to stop bleeding
☐ Bronchitis	☐ Recent use of antibiotics
☐ Difficulty breathing	☐ Impotence
☐ Long COVID	☐ Cold hands and feet
	☐ Hearing impairment
	☐ Ear ringing

Lab results: You may include copies of lab results or authorize us to log into your medical records.

What are the main health problems for which you were seeking treatment (can add detail on the back):

What other forms of treatment have you sought?

List any other health problems you now have:

List any allergies, food sensitivities, or food cravings that you have:

List any accidents, surgeries, or hospitalizations, including dates:

I certify that my Personal Health History is complete and true to the best of my knowledge. I understand that my medical records are completely confidential, and my information is shredded after intake, locked at all times, and stored digitally in a manner compliant with personal health information guidelines under HIPAA. No personal information will be released to any other medical provider without my written permission.

Signature _____ Date _____

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Acknowledgement of Privacy Practices

Acknowledgment of Privacy Practices
We are required by law to inform you of how your protected health information may be used and disclosed. Our full Notice of Privacy Practices is available upon request and outlines your rights regarding this information.

We do not bill insurance or send records to outside providers unless specifically requested and authorized by you in writing.

All records are stored in a secure, encrypted, cloud-based system. No paper records are kept. Sensitive information is never shared without your written consent, except as required by law.

Email Communication We use encrypted email for any messages containing your health information. When you receive a secure email from us, you may need to log in to a secure portal to open or download the file. This protects your information in transit.

Exceptions Where Disclosure May Be Required You express intent to harm yourself or another person. A valid court order or subpoena is received. As otherwise required by law.

Text Message Communication You may text us on the clinic line for scheduling purposes only, such as cancelling or rescheduling an appointment or letting us know you are running late. *Under no circumstances may medical questions, health information, symptoms, diagnoses, or any clinical matter be communicated by text.* All medical questions must be addressed by phone, in person, or via encrypted email. Text messages from our office will never contain medical information, diagnoses, prescriptions, or billing details. By signing below, you also consent to receive these limited text messages on the mobile number you provide. You can opt out at any time by replying STOP or notifying our office in writing.

Recording We do not record sessions. You may not record sessions by any means including phone, video, or any other device.

Records Retention and Practice Closure Records are retained for a minimum of 10 years. If this practice closes or you transfer care, you will be notified in writing with instructions for accessing or transferring your records.

By signing below, you confirm that:

- You have received (or have been offered) a copy of our Notice of Privacy Practices.
- You understand that all records are stored digitally and confidentially.
- You authorize us to use your information for treatment purposes and required operations only.
- You consent to receive logistics-only text messages as described above.

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- You understand that emails containing health information will be encrypted and may require a secure login to access.

You may revoke this consent in writing at any time. A revocation does not apply to any disclosures made while this consent was in effect.

Patient Name: _____
Signature: _____
Date: _____

Mobile number for texts: _____

(Optional if applicable) Representative Name: _____

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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.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

.

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

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Self-Pay Financial Agreement

We are a private-pay acupuncture clinic. While we do not bill insurance directly, superbills are provided upon request for patient reimbursement.

All sessions are time-based, meaning the clock begins at the start of the appointment and includes consultation, evaluation, and treatment time.

Rates – Time and Trauma Dependent

Initial In-Person Visit (up to 90 minutes): $250-300. If the session exceeds 90 minutes, the fee will increase based on duration. All talk time is billable.

Follow-Up In-Person Treatment: $225 - $300, time dependent

Telemedicine Consultation (75-90 minutes): $250 Includes medical record review, dietary evaluation, and referral recommendations. Treatment letter and emailed narrative included. Review of medical records is billed in 15 minutes increments if they are lengthy. We need to see records prior to the call.

Follow-Up Telemedicine (30 minutes): $125

F/up Complex Trauma or Neurological Cases: $250–$350 per session, based on time and complexity

Sessions may include any combination of the following as needed: acupuncture, herbal medicine, functional lab review, energy work, physical therapy or reflex integration, cranial sacral work, dietary assessment, or care coordination. These are integrated into the session and not itemized separately.

Cancellation Policy

- Appointments cancelled with less than 24 hours' notice will be charged a $50 fee
- Patient who no-show without notice may require prepayment or referral
- Telemedicine patient will need to reserve the first visit with a major credit card or Venmo.
- Arrival more than 15 minutes late may result in a shortened session

By signing below, I acknowledge and accept the terms of this agreement.

Patient Signature: _____

Date: _____

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