CONFIDENTIAL PATIENT INFORMATION

Date _____

Name _____

Nickname _____

Address _____

City, State, Zip _____

Home Phone #_____ **Cell Phone #**_____ **Work Phone #**_____

Sex: ☐**Male** ☐**Female** **Age** _____ **Height** _____ **Weight** _____ **Birthdate**_____

Email _____

Emergency Contact Name/Relationship _____

Emergency Contact Phone Number(s)_____

Your Employer:_____

Type of Work Performed:_____

Living Situation: ☐**Alone** ☐**With Partner** ☐**With Friends**

Spouse/Partner Name:_____

Who Can We Thank For Referring You To Our Clinic?_____

Insurance Information – ***Present Insurance Card At First Visit***

ID#_____ **Group #** _____

Flying Crane
acupuncture
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HEALTH HISTORY

Major area(s) of concern: _____

Other treatment(s) received for these concern(s): _____

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc):

_____

Are there others in your family with the same condition? _____

Other health concerns/complaints? _____

Is this related to: [ ] A Work Injury? [ ] A Car Accident? Date of Injury _____

Medications you now take:

_____ _____ _____

_____ _____ _____

Vitamins, supplements, herbs, remedies you now take:

_____ _____ _____

_____ _____ _____

Have you previously sought other complimentary health care? _____ Please check which one(s)

[ ] Naturopathy [ ] Shiatsu [ ] Massage/Body Work [ ] Chiropractic [ ] Acupuncture [ ] Osteopathy

PAST HEALTH HISTORY (include dates)

Major illnesses _____

Major surgeries _____

Other significant trauma_____

Have you been treated for any health condition in the past year? [ ] Yes [ ] No

If yes, please explain:_____

Allergies (drugs, chemicals, foods) _____

Do you smoke? [ ] Yes [ ] No

FAMILY MEDICAL HISTORY

[ ] Allergies [ ] Alcoholism [ ] Asthma [ ] Cancer [ ] Diabetes [ ] Stroke

[ ] Heart Disease [ ] High Cholesterol [ ] High Blood Pressure

[ ] Back Problems (describe) _____

[ ] Other (describe) _____

Check any of the following diseases and conditions you have or have had:

[ ] Alcoholism	[ ] Arthritis	[ ] Diabetes
[ ] Anemia	[ ] Cancer	[ ] Epilepsy
[ ] Appendicitis	[ ] Chicken Pox	[ ] Goiter

[ ] Heart Disease
[ ] High Cholesterol
[ ] Influenza
[ ] Malaria
[ ] Measles
[ ] Mental Disorder
[ ] Mononucleosis
[ ] Mumps
[ ] Pleurisy
[ ] Pneumonia
[ ] Rheumatic Fever [ ] Tuberculosis
[ ] Tattoos
[ ] Sexually Transmitted Disease
[ ] Whooping CougH
[ ] Dental work (including silver fillings

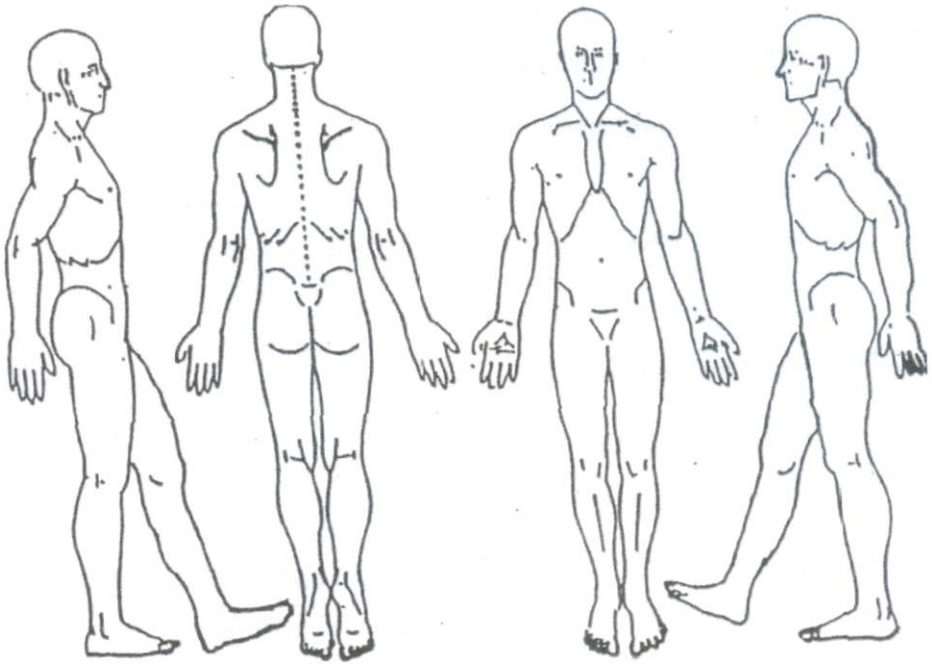
PLEASE MARK AREAS OF CONCERN

Musculo-Skeletal
[ ] Low Back Pain
[ ] Pain Between Shoulders
[ ] Neck Pain
[ ] Arm Pain
[ ] Joint Pain/Stiffness
[ ] Walking Problems
[ ] Pained/Clicking Jaw

Nervous System [ ]
Numbne
ss
[ ] Dizziness
[ ] Forgetfulness
[ ] Confusion/Depression
[ ] Fainting
[ ] Convulsions
[ ] Cold/Tingling Extremities

Cardio-Vascular [ ]
Chest
Pain
[ ] Short Breath
[ ] Blood Pressure Problems
[ ] Irregular Heartbeat
[ ] Lung Problems/Congestion
[ ] Varicose Veins
[ ] Ankle Swelling

Gastro-Intestinal
[ ] Poor/Excessive Appetite
[ ] Excessive Thirst
[ ] Frequent Nausea
[ ] Diarrhea
[ ] Constipation
[ ] Hemorrhoids
[ ] Liver Trouble
[ ] Gall Bladder Problems
[ ] Abdominal Cramps



[ ] Gas/Bloating After Meals
[ ] Heartburn/Indigestion
[ ] Black/Bloody Stool
[ ] Colitis/Irritable Bowel
[ ] Frequency of Bowel Movements

Eye, Ear, Nose, Throat [ ]
Vision
Problems
[ ] Dental Problems
[ ] Sore Throat
[ ] Hearing Difficulty
[ ] Ear Aches
[ ] Stuffed Nose
[ ] Ringing in Ears

Skin
[ ] Rash
[ ] Hives
[ ] Eczema
[ ] Psoriasis
[ ] Itch Without Eruption

Genito-Urinary
[ ] Urinary Tract Infection
[ ] Painful/Excessive Urination
[ ] Blood in Urine

General
[ ] Allergies (Seasonal)
[ ] Loss of Sleep
[ ] Fever
[ ] Headache
[ ] Migraines

Male Only
[ ] Prostate
[ ] Swollen/Shrunken Testes [ ] Sexual Dysfunction Any other Male Difficulties?

Female Only
[ ] Menstrual Irregularity

[ ] Menstrual Cramping
[ ] Vaginal Pain/Infections
[ ] Breast Pain/Lumps (Right)
[ ] Beast Pain/Lumps (Left)

Female Only (cont'd)

_____Age Menstruation Started
_____ Days Between Cycle
_____ Usual Days of Flow
_____ Maximum Pads in Day
_____ Date of Last Period
Any recent tendency to
[ ] Heavier Periods
[ ] Longer Periods
[ ] Scantier Periods [ ]
Quality of Blood:
[ ] Bright Red
[ ] Dark
[ ] Clots
[ ] Premenstrual Tension
[ ] Discharge Between Periods
_____ Number of Pregnancies
_____ Number of Living Babies
_____ Number of D & C
_____ Number of Abortions
_____ Number of Miscarriages
[ ] Cesarean(s)
[ ] Hysterectomy(s)
_____ Date of Last PAP Smear
_____ Date of Last Mammogram
_____ Method of Contraception
____Difficulty Getting Pregnant
Any other Feminine Difficulties

PATIENT'S STATEMENT OF PRIVACY RIGHTS

平 (PEACE)

和 (HARMONY)

清 (CLARITY)

Flying Crane Acupuncture, LLC

Patient's Statement of Privacy Rights

No personal information shall be given out to any entity (beyond that necessary for billing) without your express written authorization including dates of service and treatment notes.

Patient Name _____ Signature _____ Date _____

Need for Allopathic Medical Care

I understand that Dr. Marilyn Walkey, MD does not practice Western Medicine. I acknowledge that I will need to seek help from a separate, licensed physician for any healthcare needs which require standard Western Medical help.

Patient Name _____ Signature _____ Date _____

Dr. Marilyn Walkey MD, LAc
7875 SW Alden St. Portland, Oregon 97223 • (503) 608-8155 • www.flyingcraneacupuncture.com
Oregon's only MD Acupuncturist - Healing Beyond Western Medicine

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 who I am legally responsible) by the acupuncturist named 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, Tiu-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 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. 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. Burns and/or scarring are a potential risk of moxibustion and cupping. 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.

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 **X** _____

Date _____

(Or Patient Representative; Indicate Relationship If Signing For Patient)

Flying Crane Acupuncture, LLC
Marilyn Walkey, MD, LAc

AAC-FED
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 or monetary damages excedding the jurisdictional limit of the small claims court against the health care providers, 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 arbitrators 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 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 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 statue 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 thirty 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
_____ **Date** _____
(Or Patient Representative; Indicate Relationship If Signing For Patient)

OFFICE SIGNATURE X _____
Date _____

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