Welcome to Wellness

Traditional Chinese Medicine is the oldest known healthcare system and has helped millions of people.

CLINIC INFORMATION: Appointments are available Monday – Thursday.
You must provide a 24 HR notice of cancelling an appointment to avoid $25 fee.
Payment is due at the time of service.

The first visit includes obtaining a history of your health in order to select the most effective acupoints. The visit may include acupuncture, far-infrared heat, massage, neurosensory testing, electro-stim, cupping, ear tacks, gua sha and moxibustion. **I gently apply single-use sterile needles only.** On occasion, bruising may occur. If this happens, it should resolve within a couple of days.

Things to know:

- ***DO NOT MOVE AFTER THE NEEDLES ARE IN PLACE.***
- **TURN OFF YOUR PHONE 😊.**
- **DRINK PLENTY OF WATER BEFORE AND AFTER YOUR TREATMENT.**
- **DO NOT ARRIVE AT THE CLINIC HUNGRY.**
- **DO NOT PLAN ANY STRENUOUS ACTIVITY AFTER YOUR VISIT.**
- **OPTIMAL NUTRITION HELPS YOUR BODY HEAL FASTER, EAT HEALTHY FOODS FOR A MORE RAPID RESPONSE TO TREATMENTS.**
- **THE TREATMENT PROCESSES OVER APPROXIMATELY 72 HRS FOLLOWING YOUR VISIT.**

HOW MANY TREATMENTS WILL I NEED? The *basic* rule of thumb is:

- 1-4 visits to reduce acute pain.
- 1-8 visits for sustained relief.
- 1-12 visits to rebalance over-all well-being.
- 1x/ month for maintenance and anti-aging.

My goal is to help you reach your health goals and I am proud to represent an amazing form of medicine … Thank you for being here 😊

Welcome to The Wellness Center

Name_____ Today's Date_____
Telephone Number_____ Email Address_____
Mailing Address_____ Age _____
City, Zip_____ Birthdate _____
Sex: M F Usual Occupation_____
Living Situation: ف alone ف parents ف friend(s) ف family
Referred by_____ ف phone book ف newspaper ف TV
Marital Status: ف never married ف now married ف divorced ف widowed
Number of children _____ Number living with you _____
Employment Status ف school ف keeping house ف work ف full time
ف part-time ف unemployment ف disabled ف retired
Medical Insurance_____
Address _____
ID Number _____
Group Number _____ Relationship to the Insured _____

CURRENT HEALTH CONDITIONS

Please describe your present health problems and approximately how long you have had them. List in order of severity, starting with the most severe first. If you are receiving health care for any problems, list the name of the provider under the health care provider column.

	Health Problems	Date Began	Health Care Provider
1.			
2.			
3.			
4.			
5.			

Please list any operations, injuries, hospitalizations you have had to date.

_____
_____
_____
_____
_____

Emergency Contact Person_____ Ph #_____

Members of Household:

Name	Age	Relationship

Failure to provide 24 hr. notice of appointment cancellation results in a $25 fee.
initials: _____ THANK YOU!
FEMALE PATIENTS: Is there a possibility you may be pregnant? Yes No

Name:_____ Date:_____

PATIENT PROFILE

It is very important to know how long a patient has experienced his/her symptoms. Thus, it is essential to indicate time on the symptoms.

Indicate with one check any condition that you sometimes experience; use two checks for those which often occur, and three checks for symptoms that are a major concern.

WATER ELEMENT

- ❑ Hearing loss
- ❑ Dizziness
- ❑ Lower backache/neck pain
- ❑ Sinus congestion
- ❑ Edema
- ❑ Darkness under the eyes
- ❑ Emotional instability
- ❑ Aversion to cold
- ❑ Hair thinning or loss
- ❑ Premature aging
- ❑ Frequent urination
- ❑ Kidney stones
- ❑ Perspire very easily
- ❑ Weakness of legs/knees
- ❑ Asthmatic cough
- ❑ Rapid weight change
- ❑ Loose teeth
- ❑ Reduced sexual energy
- ❑ Thyroid problems
- ❑ Diabetes

WOOD ELEMENT

- ❑ Headaches
- ❑ Migraines
- ❑ Ringing in the ears
- ❑ Poor eyesight
- ❑ Eye infections
- ❑ Dry eyes
- ❑ Eczema
- ❑ Shingles
- ❑ Herpes simplex
- ❑ Warts
- ❑ Nervousness
- ❑ Convulsion, spasms
- ❑ Irritability
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Ulcer
- ❑ Vomiting
- ❑ Gallstones
- ❑ Indecisive
- ❑ Fullness below ribs
- ❑ Shoulder/neck tension
- ❑ Insomnia 11 P.M. - 3 A.M.

FIRE ELEMENT

- ❑ Dry scalp
- ❑ Skin eruptions, rashes
- ❑ Cysts, tumors
- ❑ Ear infections
- ❑ Sore throat, tonsillitis
- ❑ Lymphatic swelling
- ❑ Hot palms and soles
- ❑ Heart palpitations
- ❑ Aversion to heat
- ❑ Bitter taste in mouth
- ❑ Gum problems
- ❑ Nose bleed
- ❑ Facial redness
- ❑ Itching/burning skin
- ❑ Hot hands/feet
- ❑ Thirst
- ❑ Vivid dreaming
- ❑ Dark urine
- ❑ Night sweats

EARTH ELEMENT

- ❑ Indigestion
- ❑ Flatulence
- ❑ Food allergy
- ❑ Stomach ache/ulcer
- ❑ Diarrhea
- ❑ Anemia
- ❑ Halitosis
- ❑ Sores in mouth
- ❑ Heartburn
- ❑ Strong appetite
- ❑ Weak appetite
- ❑ Nausea
- ❑ Abdominal bloating
- ❑ Low body weight

METAL ELEMENT

- ❑ Bronchitis
- ❑ Asthma
- ❑ Shallow breathing
- ❑ Cough
- ❑ Sinus congestion
- ❑ Nasal infections

OTHER

- ❑ Fatigue
- ❑ Arthralgia
- ❑ Sciatica/nerve pain
- ❑ Cold hands/feet
- ❑ Tendonitis
- ❑ Bursitis

PAIN

(please describe below)

_____

_____

_____

OTHER COMMENTS

_____

_____

_____

HABITS, DIET, MEDICINES, ALLERGIES

Name:_____ Date _____

LAST PHYSICAL: Date_____Practitioner:_____Results:_____

HABITS: Indicate below: Heavy, Moderate, Light, or None If significant, comment.

Heavy	Moderate	Light	None	
❑	❑	❑	❑	Alcohol:
❑	❑	❑	❑	Coffee:
❑	❑	❑	❑	Tea:
❑	❑	❑	❑	Tobacco:
❑	❑	❑	❑	Exercise:
❑	❑	❑	❑	Sleep:
❑	❑	❑	❑	Appetite:
❑	❑	❑	❑	Energy:
❑	❑	❑	❑	Medication:
❑	❑	❑	❑	Vitamins:
❑	❑	❑	❑	Diet:
❑	❑	❑	❑	Teeth problems:
❑	❑	❑	❑	Drugs:
❑	❑	❑	❑	Salt:
❑	❑	❑	❑	Other:
❑	❑	❑	❑	Stress: _____ (Chemical, physical, psychological)

AVERAGE DAILY DIET

Morning:

Afternoon:

Evening:

Between Meals:

Are you now on (or have you undertaken) a restricted diet? Please describe and indicate when.

_____

_____

MEDICINES taken within the last two months (include vitamins, over-the counter drugs, herbs)

_____

_____

ALLERGIES: (Drugs, chemicals, foods. Type of reaction.)

_____

_____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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 appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

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, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). 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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

PATIENT NAME:

ACUPUNCTURIST NAME: **Jody Mangum, L.Ac.**
The Wellness Center

(Date)

PATIENT SIGNATURE: X
(Or Patient Representative)

(Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

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 California and federal law, and not by a lawsuit or resort to court process except as California and federal law provide 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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

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 healthcare 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 healthcare provider and/or other licensed healthcare 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 healthcare provider, including those working at the healthcare 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 healthcare provider, and/or the healthcare 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 equal 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 the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that, where not in conflict with this agreement, the Arbitration Rules of ADR Services, Inc. shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of the ADR Services rules are available on its website at www.adrservices.com or by calling 213-683-1600 to request a copy of the rules.

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 healthcare 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: Jody Mangum, L.Ac. The Wellness Center Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

Jody Mangum, Licensed Acupuncturist
(707) 487-4444
FAX 460-1949

THE WELLNESS CENTER
361 9th ST, Crescent City
603 Hemlock, Suite 3B, Brookings

NCCAOM 15261
CA AC-7529
OR AC-185263

PRIVACY AND CONFIDENTIALITY NOTICE

We understand the importance of keeping your personal and health information private, which includes medical and individually identifiable information (such as your name, address, telephone and Social Security number). This is a notice of the privacy practices of this office. This practice will use and disclose your personal and health information (PHI) when required to do so by federal, state and local laws. When appropriate and necessary, the minimum necessary information may be disclosed for appointment reminders, treatment, payment or health care operations such as insurance and reporting to referring providers. You may access your personal medical records upon request and copies can be provided for $25. Errors in PHI can be amended by written request. You may refuse to consent to the use or disclosure of your PHI in writing. Under this law, TWC can refuse to treat you should you choose to refuse to disclose PHI. **SITUATIONS WHERE YOUR PHI MAY BE DISCLOSED:**

TREATMENT - PHI may be disclosed to health care providers who require this information to treat you.
PAYMENT – We may disclose PHI to insurance companies as necessary for reimbursement.
APPOINTMENT REMINDERS – We may leave a message or send a postcard on occasion. Please notify us if you disapprove of such correspondence.

TEXT MESSAGING, CELLULAR PHONES AND EMAIL ARE NOT CONSIDERED HIPAA COMPLIANT IN MOST CASES.
PLEASE NOTIFY JODY IF YOU *DO NOT* WISH TO RECEIVE UNENCRYPTED COMMUNICATIONS.

PUBLIC HEALTH & SAFETY – PHI may disclose to the extent necessary to avert a serious and imminent threat to your health or safety or the health and safety of others. This includes if we reasonably believe you are a possible victim of trafficking, abuse, neglect, domestic violence and other such crimes.
PROCESS & PROCEEDINGS – PHI may be disclosed in response to court order subpoena, discovery request or other lawful process.
LAW ENFORCEMENT – PHI may be disclosed to law officials in suspected trafficking, fugitive, material witness, crime victim or missing persons.
INFORMATION NOT PERSONALLY IDENTIFIABLE – PHI may be disclosed which does not personally identify you or reveal who you are.
FRIENDS & FAMILY – PHI can be disclosed only with your verbal agreement to do so or when no objection to such disclosure has been raised. Inference of such consent may occur when you are accompanied by friends or family during consultation. **Please initial here if you prefer otherwise X___.**

- YOU HAVE A RIGHT TO AN ACCOUNTING OF DISCLOSURES.
- YOU HAVE A RIGHT TO REQUEST RESTRICTIONS OF DISCLOSURES.
- YOU HAVE A RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS.
- YOU HAVE A RIGHT TO A COPY OF THIS DOCUMENT BY REQUEST.

This office reserves the right to amend this notice, and to make the revisions effective for PHI we already have on file and in the future. We will post the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS – If you believe your rights have been violated, you may file a complaint with this office by contacting Jody Mangum at (707) 487-4444 or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

By signing below, you acknowledge being offered a copy for your records.

X_____ DATE_____

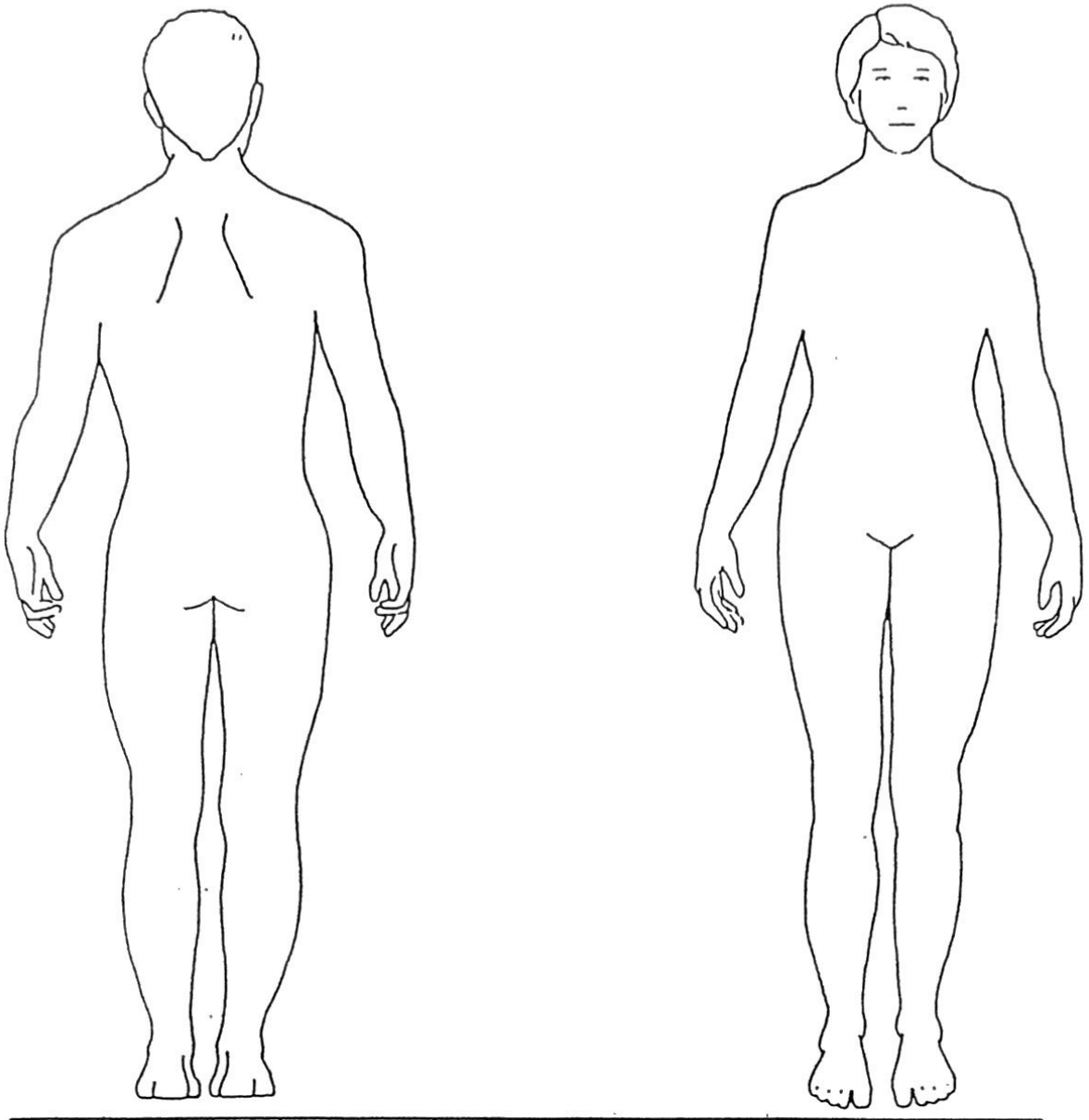
PRINT NAME:_____

NAME:_____ DATE:_____

PAIN DRAWING

Please indicate locations of pain using the key below.

Sharp/ Stabbing → ++++
Dull/ Aching → ****
Pins/ Needles → oooo
Numbness → ^^^^



ACTIVITY	NORMAL	MILDLY	MODERATELY	SEVERELY LIMITING
Lifting				
Bending				
Standing				
Walking				
Sitting				
Climbing Stairs				
Running				
Lying In Bed				
Other:_____				