Bridge Wellness
Amanda Sullivan Antonetti, L.Ac
5 Bon Air Rd, Suite 109, Larkspur, CA 94939 Ph: 415-676-1832

INFORMED CONSENT

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 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, or any other office or clinics, whether signatories to this form or not.

I understand that the methods of treatment may include, but are not limited to, acupuncture, Moxibustion, cupping, electrical stimulation, *tui-na* (traditional Chinese medical massage,) *gua sha* (Chinese therapeutic scraping), Chinese herbal prescriptions, and nutritional and lifestyle counseling. I understand that herbs may need to be prepared and decoctions consumed according to instructions provided orally and in writing. The herbs may have an unpleasant odor or taste. I will immediately notify a member of the clinic staff of any unanticipated or unpleasant effects associated with the consumption of herbs. I will keep the clinic staff informed of any pharmaceutical drug or nutritional supplement, which I have been prescribed, or I am taking, in order to allow proper timing and dosage of Chinese herbal prescriptions.

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 several days, and dizziness or fainting. Bruising is a common side effect of cupping or *gua sha*. 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, single-use, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a possible risk of Moxibustion and cupping. I understand that while this document describes the major risks of treatment, other risks may be present and other side effects may occur. The herbs and nutritional supplements (which are from plant, mineral and occasionally animal sources) that have been recommended are traditionally considered safe in the practice of oriental medicine, although some may be toxic in extreme 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 the clinic staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff 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 all 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 from this clinical staff.

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

	Date
PROVIDER'S SIGNATURE	

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CONFIDENTIAL HEALTHCARE QUESTIONNAIRE

PERSONAL INFORMATION (PLEASE PRINT)

NAME: ________________________________ SOCIAL SECURITY # ________________________________

HOME ADDRESS: ____

CITY, STATE, ZIP: ____

HOME PHONE: ____________________ WORK PHONE: ____________________

CELL PHONE: ____________________ EMAIL: ____________________________

OCCUPATION: ____

BIRTH DATE: ____________________________ AGE: _________ GENDER ___M ___ F

MARITAL STATUS ___ S ___ M ___ D ___ W NUMBER OF CHILDREN _____

FAMILY PHYSICIAN: ___________________________ PHONE: ___________________________

EMERGENCY CONTACT: ________________________________ PHONE: ___________________________

INSURANCE INFORMATION

INSURANCE ID/CLAIM#: _________________________ GROUP #: _________________________

INSURANCE COMPANY: ____

CLAIMS ADDRESS: ____

INSURANCE COMPANY PHONE NUMBER FOR PROVIDERS: ______________________________________

TYPE OF CASE (CIRCLE ONE): HEALTH INSURANCE WORKERS COMPENSATION PERSONAL INJURY

ATTORNEY ADDRESS: ____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? We'd like to thank them.

Name:____

CANCELLATION POLICY

PLEASE GIVE AT LEAST 24 HOURS NOTICE OF CANCELLATION, AT WHICH TIME WE CAN EASILY RESCHEDULE YOUR APPOINTMENT. YOU ARE EXPECTED TO PAY FOR THE TIME SET ASIDE FOR YOU IN THE CASE OF ANY MISSED APPOINTMENT, OR APPOINTMENT CANCELLED LESS THAN 24 HOURS IN ADVANCE.

I have read and understand my responsibility for payment of services. I have received a copy of the clinic financial policy.

SIGNATURE ________________________________ DATE ________________________

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HEALTH HISTORY

This confidential health history packet provides vital information and helps determine the best plan of care for you. Please print clearly and answer each question completely.

Name______________________________________ Age_______ Date_____________________

Reason for your visit today:

Check the appropriate box if you have ever experienced any of the following.

- ☐ Adverse reaction to medical treatment
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis or rheumatism
- ☐ Artificial heart valves or joints
- ☐ Bleeding disorder
- ☐ Blood disease
- ☐ Cancer or tumor
- ☐ Chemical dependency
- ☐ Diabetes
- ☐ Eating disorders
- ☐ Eye disorders
- ☐ Gout
- ☐ Headaches
- ☐ Heart disease
- ☐ Hemophilia
- ☐ Hepatitis, Jaundice or Liver disorder
- ☐ Herpes
- ☐ High blood pressure
- ☐ Immune disorder
- ☐ Kidney disorder
- ☐ Low blood pressure
- ☐ Musculo-skeletal disorder
- ☐ Organ transplant
- ☐ Pacemaker
- ☐ Respiratory disorder
- ☐ Rheumatic fever
- ☐ Sciatica
- ☐ Seizures/Epilepsy
- ☐ Skin disorders
- ☐ Special diet
- ☐ Stomach or intestinal disorder
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Transfusion (before March 1985)
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract disorder
- ☐ Venereal disease
- ☐ Other_______________________

Is there anything else we should know about your medical history?

____

Medications & Supplements: Please check the box to indicate what you are currently taking.

- ☐ Antacids
- ☐ Aspirin
- ☐ Cold or Flu medications
- ☐ Diet pills
- ☐ Hay fever medication
- ☐ Ibuprofen
- ☐ Laxatives
- ☐ Oral contraceptives
- ☐ Sleeping pills
- ☐ Tranquilizers
- ☐ Herbs
- ☐ Vitamins

Please list any medications you are currently taking that are not listed above:

____

Please list any allergies to medications you have:

____

Habits: Please mark any of the habits listed below which apply to you.

Mark an X for current habits. Mark a √ for past habits.

Tobacco use	☐ Yes	☐ No	If yes, # of cigarettes / day ________________	age started____________
Alcohol use	☐ Yes	☐ No	If yes, # of drinks / week _________________	age started ___________
Caffeine use	☐ Yes	☐ No	# of soda/day _________ # coffee /day______	# tea /day ____________
Drug use	☐ Yes	☐ No	Type(s)Amount / Age started: __________________________	
Do you exercise?	☐ Yes	☐ No	What type of exercise and how often?______________________________	

Outlook: How do you feel about the following areas of your life? Please indicate any problems you are experiencing.

	Great	Good	Fair	Poor	Bad	Your Comments
Spouse or significant other						
Family						
Diet						
Sex						
Self						
Work						

Major Hospitalizations: If you have ever been hospitalized for any serious medical illness or operation, write in your most recent hospitalizations below. If you have had more than three such hospitalizations check this box ☐. Do not include pregnancies.

1st Hospitalization____

year operation or illness hospital/city/state

2nd Hospitalization____

year operation or illness hospital/city/state

3rd Hospitalization____

year operation or illness hospital/city/state

Women's Obstetric History: Please fill in completely:

Total # of Pregnancies_________ Living___________ Ectopics_____________ Miscarriages___________

Induced Abortions: # and years_______________________

Current Care:

Are you currently under the care of a Medical Doctor? ☐ Yes ☐ No

Name of Medical Doctor:_________________________________

Phone of Medical Doctor: _________________________________

Date of Last Physical Exam: _______________________________

Have you ever been treated with acupuncture or Chinese medicine? ☐ Yes ☐ No

Name of previous Acupuncturist: __________________________

What other forms of treatment have you sought for your current medical condition? ______________________

____

Signature ____Date____________________