Angel Clark, M.S., L.Ac.
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415-710-4833
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Welcome to Energetic Therapeutics.
If you are uncomfortable about filling in any part of this form, feel free to leave the space blank.

Today's Date: _____/_____/_____

Personal Information

Last Name: _____ First Name: _____

Home Phone: _____ Cell: _____ _____

Email: _____ Occupation: _____

Street Address: _____

City: _____ Zip Code: _____

Birth Date: _____/_____/_____ Age:_____ Height: _____ Weight: _____

Marital Status: ____Single ____Married ____Partnered ____Separated ____Divorced ____Widowed

Spouses Name: _____ Age: _____ Occupation: _____

In case of Emergency, who should we contact?: _____

Relationship: _____Phone Number: _____

How did you hear about us:_____

Health Information

Reason for your visit today: _____

How long have you had this condition?_____

Does it affect your: Sleep _____ Work _____ Other _____

What seemed to be the initial cause?

_____

What seems to make it
better?_____

What seems to make it worse?_____

Primary Care Physician's name:_____

Physician's contact information:_____

Are you under a physician's care now? _____YES _____ NO

For what? _____

Please list any diagnosis you have had in the past, medical or psychological:_____

_____

Have you had acupuncture before? _____YES _____ NO_____Present

Chinese Herbal Medicines? _____YES _____ NO_____Present

Previous acupuncturist name?_____

Date or years of treatment?_____

What did you like or dislike about previous acupuncture treatment?_____

_____

Do needless make you nervous? _____YES _____ NO

Energetic Therapeutics_____

Do you have a history of fainting? _____YES _____ NO

Is your blood pressure? _____High _____Low _____Average

How often do you exercise and what type? _____

Describe your typical diet_____

How often per week do you drink coffee, caffeinated teas, and/or soft drinks?_____

How often do you drink alcohol per week and how much?_____ _

Surgeries, Traumas (falls, accidents, etc..) : (include dates) _____

Allergies: _____

Please list all medications and supplements you are currently taking:
Medications/Supplements/Dosage Reason/Objective /Date Started

_____

_____

Family History Information: (*All information provided is held strictly confidential)*

Illness: Father Mother Sibling(s) Grandparents Aunt/Uncle

Cancer _____

Diabetes _____

High Blood Pressure _____

Heart Disease _____

Allergies _____

Drug Abuse _____

Alcoholism _____

Mental Illness _____

Seizures _____

Strokes _____

Other:_____

Medical Conditions/History: *(Circle any conditions you have had, or are currently experiencing)*

____Aids/HIV	_____Cancer	____Hepatitis	_____Osteoporosis
_____Alcoholism	_____ Diabetes	_____Herpes	_____Pacemaker
_____Allergies	_____ Emphysema	_____Lyme Disease	_____Pneumonia
_____Tuberculosis	_____Appendicitis	_____ Epilepsy	_____High Blood Pressure
_____Arteriosclerosis	_____ Goiter	_____Measles	_____ Rheumatic Fever
_____Arthritis Gout	_____Menopause	_____Scarlet Fever	_____Asthma
_____ Stroke	_____Seizures	_____Venereal Disease	_____Typhoid Fever
_____Heart Disease	_____Ulcers	_____Polio	_____Thyroid Disorder
_____ Multiple Sclerosis			

Gynecological History: *(Men skip section)*

Age at your first period: _____ First day of your last period? _____ Period regular? ___ Yes ___No

Number of days between periods: _____ Number of days of bleeding: _____

Amount of bleeding? _____LIGHT _____MEDIUM _____HEAVY

What color is the blood? _____PURPLE _____BROWN _____BLACK _____BRIGHT RED _____PINK

Is there clotting? _____YES _____ NO

Do you bleed or spot between periods? _____YES _____ NO

Have you ever taken medication to bring on your period? _____YES _____ NO

Do your breasts become tender pre-menstrually? _____YES _____ NO

Do you have pre-menstrual low back pain? _____YES _____ NO

Do you have pain with menstruation? _____YES _____ NO

Degree of pain: _____MILD _____MODERATE _____SEVERE

Pain relieved by over-the-counter medications? _____YES _____ NO

Does the pain start with the onset of bleeding? _____YES _____ NO

Begin before the onset of bleeding? _____YES _____ NO

Persist more than 48 hours? _____YES _____ NO

Do you ovulate on your own? _____YES _____ NO

Do you experience pain during ovulation? _____YES _____ NO

On which day of your cycle do you ovulate? _____/_____/_____

Do you have vaginal discharge? _____YES _____ NO

Associated with itching or burning? _____YES _____ NO

Associated with unusual odor? _____YES _____ NO

Do you get yeast infections? _____YES _____ NO

Do you experience pain during intercourse? _____YES _____ NO

Do you have a gynecologist? _____YES _____ NO

Gynecologist name:_____ Contact information:_____

When was your last pap smear? _____ Result? _____

Have you ever had an abnormal pap? _____YES _____ NO

If yes, what follow up was necessary_____

Have you ever had a mammogram? _____YES _____ NO

Have you ever had a sexually transmitted disease? _____YES _____ NO

Chlamydia, Gonorrhea, Herpes, Other: _____

When? _____ Was it treated? _____

Do you experience milk or other discharge from your nipples? _____YES _____ NO

Have you ever used an IUD? _____YES _____ NO

Have you ever used the Oral Contraceptive Pill? _____YES _____ NO

If yes, for how long? _____ When did you last use it? _____

How long did it take for your menses to regulate? _____

Any chance you are currently pregnant? _____YES _____ NO

Please indicate number of:

_____ Pregnancies _____ Premature Births _____ Children _____ Ectopic

_____Miscarriages _____ IVF's _____ Abortions _____ IUI's

Women Fertility

Previous gynecological surgeries: _____

Date of procedure :_____

C-Section births _____

Dilation & Curettage (D&C) _____

Hysterosalpingogram (HSG) _____

Hysteroscopy _____

Laparoscopy _____

Other: _____

Previous Diagnostic Assessments

____ Advanced Maternal Age

____ Amenorrhea

____ Anovulation

____ Cervical Stenosis

____ Elevated FSH

____ Endometriosis (mild, moderate, severe)

____ Fallopian Tube Blockage

____ Habitual Miscarriage

____ Hostile Cervical Mucus

____ Hyperprolactinemia

____Phospholipid Antibodies

____ Luteal Phase Defect _____Other: _____

____ Menorrhagia

____ Ovarian Cyst

____ Ovarian Hyperstimulation Syndrome (OHSS)

____ Pelvic Adhesions

____ Pelvic Inflammatory Disease (PID)

____ Polycystic Ovarian Syndrome (PCOS)

____ Premature Ovarian Failure

____ Unexplained Infertility

____ Uterine Fibroids or Polyps

List any fertility drugs you have taken:

_____

Medications you use currently: _____

How long have you been trying to get pregnant? _____

Women Fertility

Have you had a fertility workup and where? _____ _____YES _____ NO

What were the results? _____

How is your sexual energy?_____ Low _____Normal _____High

Do you use vaginal lubricants? _____YES _____ NO

Previous Gynecological surgeries: _____

Date of procedure**?** ____/_____/_____

Do you have a stressful occupation? _____YES _____ NO

Do you exercise regularly? _____YES _____ NO

How often? _____

Do you have excessive facial hair? _____YES _____ NO

Do you have excessively oily skin? _____YES _____ NO

Have you experienced excessive loss of head hair? _____YES _____ NO

TCM-Five Element Information

**Please check symptoms you are presently experiencing or experienced recently*

Kidney (Water Yin Function)

_____Cold hands _____Hot body temperature _____ Profuse perspiration _____ Perspire easily

_____Cold feet _____Cold body temp _____Lack of perspiration _____Cold hips/buttocks

_____Sweaty palms _____Afternoon Flushing _____Night sweating _____ Incontinence

_____Sweaty feet _____Hot Flashes _____Strong thirst _____ Night time urination

_____Low back weakness or pain _____Vaginal dryness

_____Fertile cervical mucus _____Dizziness

_____Dark circles around your eyes _____Ringing in your ears

_____Low back pain before your period _____Low libido

_____Feet cold, especially at night _____Early morning loose stools

_____Cold menstrual cramps _____Premature gray hair

Urinary (Water Yang Function)

_____Normal color _____Reddish color _____Small amount of dribbling

_____Dark yellow _____Strong odor _____Cloudy _____UTI

_____Large amount _____Clear color _____Very frequent _____Pain/burning urination

Frequency:_____

Times at night: _____

Times during the day: _____

Lung (Mental Yin Function)

_____Persistent cough _____Chronic allergies _____Dry or flaky skin

_____Nose bleeds _____Nasal dryness _____Sneezing

_____Difficulty breathing _____Sinus congestion _____Sore throats

_____Wheezing _____Cigarette smoking _____Allergies

If you are a smoker, how many cigarettes per day? _____

How long have you been smoking? _____ Do you want to quit?_____

Libido (Essence Function)

_____Normal sex drive _____Diminished sex drive _____Lack of desire

_____High sex drive _____Sexual addiction

Spleen (Earth Yin Function)

Energy level: _____High ____Normal _____ Low

_____Poor appetite _____Feel heavy/sluggish _____ Energy lower after a meal

_____Heaviness in the head _____Feel bloated after eating _____ Poor circulation

_____Crave sweets _____Varicose veins _____Bruise easily

_____Loose stools _____ Tired around ovulation _____Spot before your period comes

_____Abdominal pain _____Tired around menstruation _____Nose cold

_____Indigestion _____Nausea _____ Gas

_____Often sick _____ Hypoglycemia

Stomach (Earth Yang Function)

_____Stomachache _____Stomach ulcer _____Acid reflux _____Heartburn

_____Belching _____Hiccups _____Mouth ulcers _____Bleeding Gums

_____Ravenous appetite _____Bad breath _____Nausea _____Vomiting

Heart (Fire Functions)

_____Heart palpitations _____Forgetfulness _____Hot hands

_____Anxiety _____Depression _____Hot feet

_____Mental restlessness _____High blood pressure _____Rapid heart beat

_____Chest pain _____Heart murmur _____Restless dreams

_____Hemophilia _____Tongue ulcers _____Insomnia

_____Manic moods _____Speech impediment _____Arrhythmia

_____Severe shyness _____Low blood pressure _____Wake up in the early am

Bowl and Elimination (Mental Yang Function)

_____Loose stools _____Constipation _____Difficulty moving bowels

_____I.B.S or colitis _____Diarrhea _____Blood in stools

_____Stools: Small, hard, dry _____Crohn's disease _____Incomplete stools

_____Mucus in stools _____Less than 1 BM/Day _____Eating disorder

(Bulimia, Anorexia, Over Eating)

Liver and Gallbladder (Wood Function)

_____Chest pain _____Irritability _____Depression _____Skin rashes

_____Chest tightness _____Easy to anger _____Pain in the ribcage _____Acne

_____All over body tension _____Easily frustrated _____Headaches _____Muscle spasms

_____Convulsions _____Chronic neck tension _____Migraines _____Muscle cramps

_____Numbness/tingling ____Shoulder tension _____Gall stones _____Lump in throat

_____Eye dryness _____Seizures _____ Ringing in the ears _____PMS

_____Breast tenderness _____Nipple pain _____ Painful periods

_____ Wake with bitter taste in mouth

_____ Difficulty falling asleep at night

_____ Alternating diarrhea and constipation

_____Easily overwhelmed by stressful circumstances

Blood (Wood, Earth, Fire)

_____Menses scanty or late

_____Dry skin

_____Chapped lips

_____Weak or brittle nails

_____Losing head hair

_____Difficulty concentrating

_____Fainting

_____Blurry vision

_____Poor night vision

_____Hair dry/brittle

Accumulated Dampness

_____Mental fogginess

_____Mental sluggishness

_____Poor mental focus

_____Swollen hands

_____Swollen feet

_____Joint stiffness/ache

_____Edema in the legs

_____Edema in the abdomen

_____Chest congestion

_____Heaviness of the head, the limbs or of the whole body

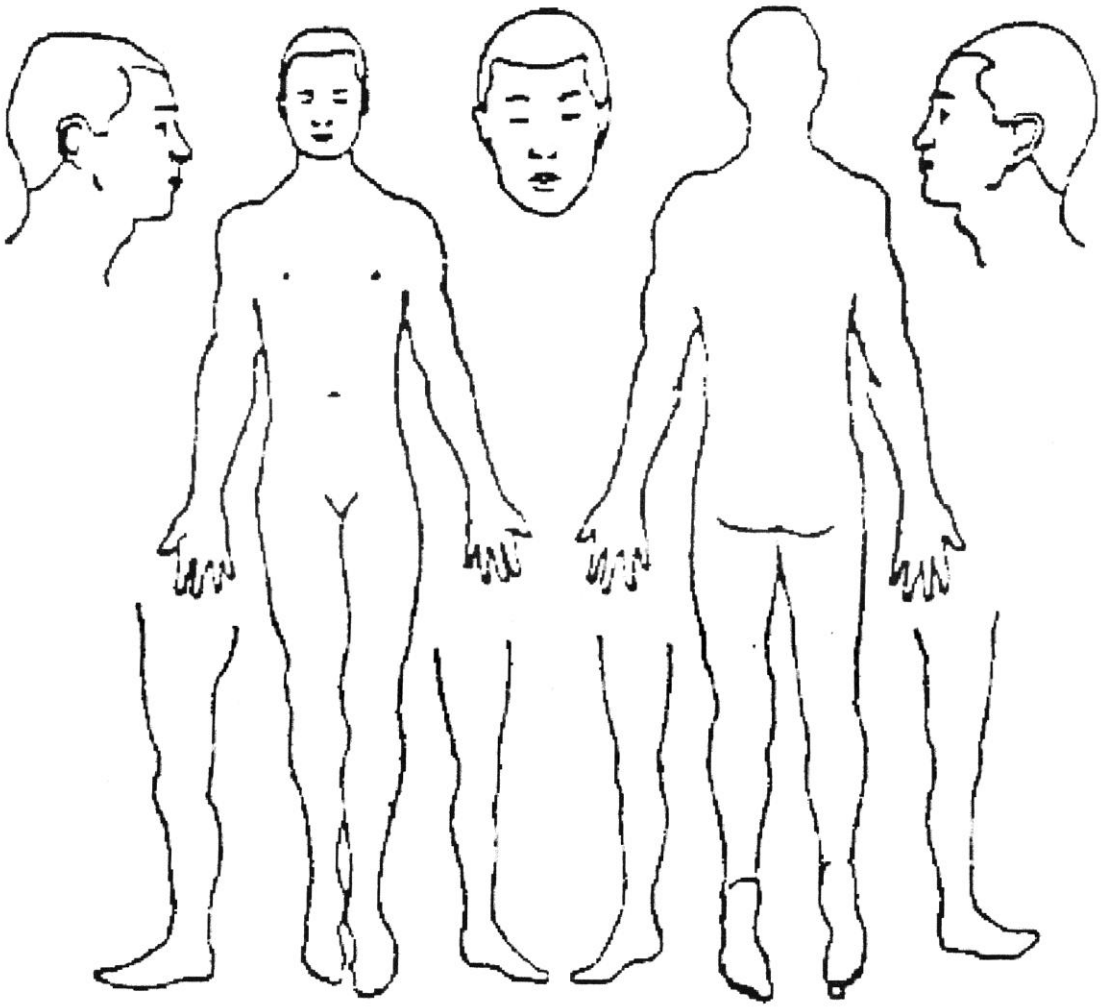
Is there anything else you would like to discuss?

_____

_____

_____

On the diagrams below, please circle all areas that are causing you pain or distress.



Comments: Are there any additional symptoms or issues that you would like to discuss?

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Patient Consent for Use and Disclosure of Protected Health Information (PHI)

With my consent, Energetic Therapeutics may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

With my consent, Energetic Therapeutics may call my home or any other designated location and leave a message on voicemail or in person in reference to any items that assist Energetic Therapeutics in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Energetic Therapeutics may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient's statements as long as they are marked personal and confidential.

With my consent, to Energetic Therapeutics may email me appointment reminders and patient's statements. I have the right to request that Energetic Therapeutics restrict how it uses or disclosed my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bounded by this agreement.

By signing this form, I am consenting to Energetic Therapeutics use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Energetic Therapeutics may decline to provide treatment to me.

Signature of Patient or Legal Guardian:

PRINT NAME_____**DATE:**_____

SIGNATURE_____**DATE:**_____

24 HOUR CANCELLATION POLICY

I understand this office requires a 24-hour cancellation notice for appointments. Cancelling appointments within 24-hours or missing an appointment (except for valid emergency situations) will result in a charge of up to 100% of the normal fee for service. I understand and agree to uphold this cancellation policy.

PRINT NAME____ _____**DATE:**_____

SIGNATURE_____**DATE:**_____

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Arbitration Agreement & Informed Consent

PATIENT NAME:

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 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 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 binds 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 call 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 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 allparties. 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 the 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 writ ten 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 noneconomic 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 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 provide wi thin 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 JURY OR COURT TRIAL. SEE ARTICLE 1 OF THISCONTRACT.

PATIENT SIGNATURE _____DATE:_____

OFFICE SIGNATURE_____DATE:_____

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Informed Consent

PATIENT NAME:
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 Angel Clark, LAc 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 Angel Clark, LAc, including those working at the 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 lifestyle and nutritional counseling. I understand that the herbs may be in capsule or tea pill form or need to be prepared and the teas consumed according to the instructions provided orally and in writing. I will immediately notify Angel Clark, LAc 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 I 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 or treatment, other side effect 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 Angel Clark, LAc if I am or become pregnant. I do not expect the Angel Clark, LAc to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on Angel Clark, LAc to exercise judgment during the course of treatment which Angel Clark, LAc thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand Angel Clark, LAc 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 _____Date:_____

OFFICE SIGNATURE _____ Date:_____