Dr. Kristen 'tank' Conner, LAc
Living Tree Acupuncture
405 Kains Avenue, Ste. 204, Albany CA 94706
(510) 558-8062

Date_____

Name_____
First MI Last

Address_____
Street City State

Primary Phone_____ **Email**_____
Home / Work / Cell

Gender Identity: _____ **Pronouns:** _____

Date of Birth_____ **Age**_____ **Occupation**_____

Medical Doctor _____
Name Address Phone

Emergency Contact_____
First Last Relationship

_____
Home Work Cell

How did you find out about this practice? _____

CANCELLATION & LATE APPOINTMENT POLICY

Twenty-four-hour notice for cancellations is required. Less than twenty-four hours notice will be billed at one half the normal fee. Missed appointments will be billed at the full rate. If an emergency prevents you from keeping your appointment, special arrangements can be made at the practitioner's discretion. Please be on time. If you know that you will be late, please call. Every effort will be made to reschedule you for a later time.

HIPPA PRIVACY POLICY

I have been informed that this office's HIPPA/Privacy Policy is available by request as well as on the office's website.

_____ _____
Patient Signature Date

MEDICAL HISTORY

Chief Complaints / Reasons for Initiating Care *(Use back of paper if needed.)* **Date/s of Onset**

_____ _____

_____ _____

_____ _____

Please check all of the following conditions that you have now or have had:

Self	Relative		Date of Onset & Description
		Fainting	
		Hypertension	
		Heart Disease	
		Lung Disease	
		Liver or Kidney Disease	
		Diabetes	
		OB/GYN/URO Problem	
		Blood or Bleeding Disorder	
		Bone or Joint Problem	
		Neurological Disorder	
		Immune Disease	
		Psychological Disorder	
		Cancer	
		Food, Drug, or Skin Allergy	
		Other Condition	

Please indicate any hospitalizations, surgeries or serious injuries you have had. *Use back of paper if needed.*

Date	Condition or Procedure

Please list all current medications, hormones, and supplements and their dosages. *Use back of paper if needed.*

Dosage	Medication or Supplement

Is there anything else that I should know about you, your body, or your history? Y / N

Is anyone hitting, hurting, belittling, demeaning, pressuring, or touching you in an unwanted manner? Y / N

Do you feel that anyone is pressuring or taking advantage of you with regard to your finances? Y / N

If you answer yes to any of these questions, please elaborate on the back of this page.

This information is true and correct to the best of my knowledge. _____

Patient Signature Date

Informed Consent to Receive Treatment and Care

You are always encouraged to ask for more details if you wish. Contraindications (symptoms or conditions that make a particular treatment inadvisable) for acupuncture treatment and use of certain herbs include a history of bleeding disorder or current anticoagulation therapy, an implanted pacemaker or prosthetic heart valve, use of certain medications, and/or pregnancy. It is important that you notify your practitioner if any of these apply to you.

Please initial next to each of the following statements:

_____ I understand that the diagnosis given to me conforms to the principles of Traditional Chinese Medicine (TCM) and in no way purports to replace allopathic medical evaluation, diagnosis, or treatment.

_____ I have provided a full history and description of my medical complaints and health status which is complete and accurate. I understand the need for communication with all of my health care providers regarding my health status is both necessary and ongoing.

_____ I understand that no guarantee has been made concerning the use and effects of TCM. I understand that, in some cases, symptoms may relapse or intensify temporarily during the course of treatment before relief is sustained.

_____ I understand that I may stop treatment at any time.

_____ I understand that while this document describes major risks of treatment, other side effects and risks may occur.

_____ **Acupuncture:** I understand that this is a technique using small, sterile, single-use, stainless-steel needles inserted at specific points in the body, sometimes with the addition of manual or electrical stimulation, causing a positive response in order to correct various ailments. The location and the application of the needles and the depth of the needle insertion is determined by the nature of the problem. I understand that the application of these needles may be accompanied by a brief painful sensation, and that there is a slight possibility of minor swelling, bleeding, discoloration of the skin, hematoma, a bruise at the site of needling, or fainting. Momentary euphoria or lightheadedness may occur after treatment. Some very rare risks of acupuncture include miscarriage, pneumothorax (air in the chest cavity that could cause a collapsed lung), and infection.

_____ **Moxibustion:** I understand that this is the application of indirect heat supplied by burning the herb *Folium Artemesiae vulgaris* over a single acupuncture point or group of points. This generally produces a sensation of relaxation. The area being treated may remain red and warm for several hours after treatment. In rare instances, a minor burn may occur at the site of moxibustion.

_____ **Cupping:** I understand that this is the application of round vacuum cups to enhance blood circulation to the designated area. This method may produce a deep redness, discoloration, and on rare occasions a minor blister that may persist for up to a week. These marks may resolve on their own and are not indications of a complication or injury.

_____ **Gua sha or Skin Scraping:** I understand that this is the scraping of the skin with a blunt tool to enhance blood circulation to the designated area. This method may produce a deep redness, discoloration, and, on rare

occasions, a minor blister that may persist for up to a week. These marks may resolve on their own and are not indications of a complication or injury.

_____ **Acupressure/Tui Na Massage:** I understand that I may be given acupressure massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiologic functions. I am aware that the side effects that may result from this treatment include, but are not limited to: bruising, sore or achy muscles, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop treatment if it is too uncomfortable.

_____ **Infrared Heat:** I understand that this is the application of indirect heat supplied by an electric infrared heat lamp which may be used to promote relaxation, facilitate the effectiveness of needling, or to keep a patient warm while undergoing treatment. The area being treated may remain red and warm for several hours after treatment. In rare instances, a minor burn may occur at the site under the heat lamp.

_____ **Herbs and Nutritional Supplements:** I understand that substances from the *Oriental Materia Medica* may be recommended to me to treat bodily dysfunction, to modify or prevent pain perception, and to normalize the body's physiologic function. Herbs are used to facilitate the body's own restorative process. I understand that I am not required to take these substances but must follow the direction for administration and dosage if I do decide to take them.

_____ I understand that recommended herbs are traditionally considered safe in the practice of TCM, although some may be toxic in large doses. I understand that some dietary supplements are inappropriate during pregnancy, may interact with medications or other supplements, may have side effects of their own, or may contain potentially harmful ingredients not listed on the label. I also understand that most supplements have not been tested in pregnant women, nursing mothers, or children. Potential risks include, but are not limited to: allergic reactions, nausea, gas, stomachache, vomiting, headache, diarrhea, rash, hives, and tingling of the tongue. Some possible side effects of applying topical creams, liniments, ointments and plasters are rashes, hives, and tingling of the skin. I will immediately cease use of the herbs and/or supplements and will immediately notify my practitioner of any unanticipated or unpleasant effects associated with herb or supplement treatment.

_____ I understand that it is not possible to anticipate and explain all risks and complications. I understand and agree that my practitioner will exercise her best judgment during the course of treatment which she feels at the time, based on the facts known to her, is in my best interest as a patient.

_____ I hereby state that I have read, or have had read to me, and understand this form, that I have been given an opportunity to ask questions, and that all questions were answered in a satisfactory manner. I wish to proceed with TCM treatment. I understand that I am free to withdraw my consent to treatment at any time.

_____

Patient Name

_____

Signature of Patient or Authorized Patient Representative

_____

Date

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MUTUAL ARBITRATION AGREMENT
Patient / Client & Practitioner

Patient / Client Name _____

This Mutual Arbitration Agreement constitutes an integral part of a contract for massage and/or acupuncture service by and between the Massage Therapist and/or Licensed Acupuncturist, who has agreed to be bound hereunder, and the Patient:

1. It is understood that any dispute as to malpractice, that is, as to whether any 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 under California law, and not by a lawsuit or resort to court process except as California 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.

2. Such arbitration shall be in accordance with the current Commercial Arbitration Rules of the American Arbitration Association. This Mutual Arbitration Agreement shall apply to any legal claim or civil action in connection with this service against and practitioner who has agreed to be bound by this provision.

3. The execution of this Mutual Arbitration Agreement shall not be a precondition of furnishing service by the practitioner, and this Mutual Arbitration Agreement may be rescinded by written notice from the Patient / Client or Patient's / Client's representative to the practitioner within 30 days of signature.

4. This Mutual Arbitration Agreement shall bind the parties hereto, including newborns, and the heirs, representatives, executors, administrators, successors, and assigns of such parties and newborns.

5. Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency services) patient should initial here:_____
Patient / Client / Representative Initials

If any provision of this arbitration agreement is determined to be invalid or unenforceable, the remaining provisions shall remain in full force.

Copies of this document are available upon request as well as on the Practitioner's website.

NOTICE: By signing this Contract you are agreeing to have any issue of 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 / Client / Parent / Guardian / Conservator Signature Date

_____
If signed by other than the Patient / Client, indicate relationship

_____ _____
Signature of Provider Date