

New Patient Intake Form

INTAKE AND CONSENT FORMS

- Please complete before your appointment. Your information is confidential and protected (HIPAA).
- If you are unsure of an answer, leave it blank and ask clinic staff for help.
- Check all boxes ☐ that apply. Bold fields marked * must be completed.
- Use MM/DD/YYYY for dates. Complete paper OR Google Forms; you do not need to do both.

1. Patient Information

Last Name *	First Name *	Date of Visit
Date of Birth (MM/DD/YYYY) *	Sex *	
	☐ Male ☐ Female ☐ Other	
Primary Language	Phone *	
Home Address *		
City *	State *	ZIP *
Email		
Employer	Occupation	
Emergency Contact	Relationship	
Emergency Contact Phone	Phone (Alt)	

2. Insurance Information

 Show your insurance card to staff if you would like help completing this section.

Primary Health Plan	Member ID #
Subscriber Name	Subscriber ID #
Group #	Relationship to Subscriber
Secondary Insurance (if applicable)	
2nd Health Plan	Member ID #
Subscriber Name	Group #

3. Primary Care Physician

Physician Name	Phone
Physician Address	
Currently under a physician's care?	If yes, for what condition(s)?
☐ No ☐ Yes	

4. Safety Screening

Check ALL that apply.

- ☐ Pacemaker
 ☐ Insulin pump
☐ Spinal cord stimulator or other implanted electrical device
 ☐ Seizures / epilepsy
☐ Bleeding disorder (e.g., hemophilia)
 ☐ Taking blood thinners / anticoagulants
☐ Damaged heart valves or high risk of infection
 ☐ None apply
☐ Pregnant → _____ weeks / Under a physician's care? ☐ Yes ☐ No

5. Chief Complaint & Pain Assessment

Describe your reasons for visiting, most important first. Complaint 1 is required; complaints 2 and 3 are optional.

Pain scale	0	1	2	3	4	5	6	7	8	9	10
	0 = no pain				5 = moderate pain				10 = worst possible pain		

	Complaint 1 (required)*	Complaint 2 (optional)	Complaint 3 (optional)
Main symptom(s) / condition			
When did it start? (MM/DD/YYYY)			
How did it happen?			
Related to a work injury?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Pain level today (0–10)			
Interference with daily activities (0–10)			
How often do you feel this pain?	☐ Sometimes (0–25%) ☐ 26–50% of the time ☐ Often (51–75%) ☐ Constant (76–100%)	☐ Sometimes (0–25%) ☐ 26–50% of the time ☐ Often (51–75%) ☐ Constant (76–100%)	☐ Sometimes (0–25%) ☐ 26–50% of the time ☐ Often (51–75%) ☐ Constant (76–100%)
Previous treatments for this condition	☐ Acupuncture ☐ Chiropractic ☐ Physical therapy ☐ Injection ☐ Surgery ☐ Medication ☐ Massage ☐ Other	☐ Acupuncture ☐ Chiropractic ☐ Physical therapy ☐ Injection ☐ Surgery ☐ Medication ☐ Massage ☐ Other	☐ Acupuncture ☐ Chiropractic ☐ Physical therapy ☐ Injection ☐ Surgery ☐ Medication ☐ Massage ☐ Other
Progress from previous treatment	☐ Worse ☐ No change Improvement: ☐ 0–25% ☐ 26–50% ☐ 51–75% ☐ 76–100%	☐ Worse ☐ No change Improvement: ☐ 0–25% ☐ 26–50% ☐ 51–75% ☐ 76–100%	☐ Worse ☐ No change Improvement: ☐ 0–25% ☐ 26–50% ☐ 51–75% ☐ 76–100%
Goals for acupuncture treatment			
How will you track progress?			

Examples: "Sleep through the night" · "Walk around the block" · "Get through the day without medication" · "Return to work" · "Walk 30 minutes daily" · "Cook without pain"

6. Medical History

Check conditions you have been diagnosed with or treated for. ☐ None apply

- | | | | |
|--|---|---|---|
| ☐ High blood pressure | ☐ Heart disease / heart attack | ☐ High cholesterol | ☐ Stroke |
| ☐ Diabetes | ☐ Pneumonia | ☐ Asthma | ☐ Rheumatoid arthritis |
| ☐ Gout | ☐ Acid reflux / ulcers | ☐ History of blood clots | ☐ Bleeding / clotting disorder |
| ☐ Hepatitis | ☐ Liver disease | ☐ Kidney disease | ☐ Thyroid disease |
| ☐ Neurologic disorder | ☐ Tuberculosis | ☐ Osteoporosis | ☐ Palpitations |
| ☐ Peptic ulcer | ☐ Prostate problems | ☐ Convulsions / seizures | ☐ Dizziness |
| ☐ Hospitalization (reason): _____ | | ☐ Surgery (type): _____ | |
| ☐ Cancer (type): _____ | | ☐ Other: _____ | |

7. Medications, Allergies & Family History

List current medications. Staff can help if you bring your medication bottles. ☐ None

Medication	Dose	Medication	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Supplements / herbs

Allergies (medication, food, other)

☐ None

Family History (parents, siblings, children) ☐ None

- | | | | |
|--|--|---|--|
| ☐ Heart disease | ☐ Arthritis | ☐ Lupus / autoimmune | ☐ High blood pressure |
| ☐ Diabetes | ☐ Cancer: _____ | ☐ Other: _____ | |

8. Current Symptoms & Lifestyle

Check all current symptoms.

- | | | | | |
|-----------------------------|--|--|--|--|
| General | ☐ Unexplained weight loss/gain | ☐ Fever/chills | ☐ Chronic fatigue | ☐ Breast lumps |
| Cardiovascular | ☐ Chest pain | ☐ Irregular heartbeat | ☐ Heart murmur | ☐ Leg/ankle swelling |
| Musculoskeletal | ☐ Arthritis | ☐ Osteoporosis | ☐ Prior fractures | ☐ Muscle weakness |
| Gastrointestinal | ☐ Heartburn/reflux | ☐ Constipation | ☐ Diarrhea | ☐ Nausea/vomiting |
| Neurologic | ☐ Balance problems | ☐ Dizziness/vertigo | ☐ Headaches/migraines | ☐ Weakness |
| | ☐ Numbness | ☐ Seizures | | |
| Respiratory | ☐ Shortness of breath | ☐ Sleep apnea | ☐ Asthma/COPD | ☐ Chronic cough |
| Mental health | ☐ Depression | ☐ Anxiety | ☐ PTSD | ☐ Insomnia |
| | ☐ Seeing a mental health professional | | | |
| Urinary/reproductive | ☐ Painful urination | ☐ Urinary infection | ☐ Frequent urination | ☐ Abnormal menstruation |

Lifestyle

Tobacco: ☐ Never ☐ Former ☐ Current Alcohol: ☐ No ☐ Yes Caffeine: ☐ No ☐ Yes
 Recreational drugs: ☐ No ☐ Yes Water (glasses/day): _____ Sleep (hours/night): _____
 Overall health: ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor
 How did you hear about us? ☐ Internet ☐ Friend/family ☐ Doctor ☐ Insurance ☐ Other: _____

9. Patient Certification

I certify that the above information is complete and accurate to the best of my knowledge. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered. I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage. I understand that my practitioner may need to contact my Primary Care Physician if my condition needs to be co-managed. Therefore, I give authorization to my practitioner to contact my medical doctor if necessary. I authorize release of any information acquired in the course of my treatment to my insurance carrier(s) as necessary for payment of benefits.

10. Informed Consent for Treatment

In plain language: treatments such as acupuncture, cupping and herbs can cause bruising, soreness or dizziness. Read the following and ask questions before signing. You may withdraw consent at any time.

Treatments at this clinic may include acupuncture, herbal medicine, cupping/fire cupping, moxibustion, Tui-Na massage, gua sha, infrared therapy and other Traditional East Asian Medicine modalities. These therapies can be effective, but like any health treatment, they carry potential risks.

A. Acupuncture - possible side effects

- Drowsiness or lightheadedness may occur, especially after the first session. Do not drive or use heavy machinery if affected.
- Minor bleeding or bruising at needle sites may occur and usually resolves on its own within a few days.
- Temporary soreness at needle sites for 24–48 hours is common and generally a normal response.
- In fewer than 3% of patients, symptoms may worsen for 1–2 days before improving. Tell us if this lasts over 2 days or feels severe.
- Fainting can occur if you are anxious, hungry or tired. Eat a light meal before your visit and tell staff if you feel unwell.
- Infection is extremely rare. We always use sterile, pre-packaged, single-use needles.
- Broken needles are very rare. Remain still while needles are in place.

B. Cupping - possible side effects

- Circular bruising or discoloration is normal and expected, and usually fades within 3–10 days.
- Fire cupping may rarely cause skin irritation or blisters; your skin is monitored throughout treatment.
- Mild soreness at cupping sites may last 1–2 days.

C. Herbal medicine and supplements - possible side effects

- Some herbs interact with blood thinners, heart medications and diabetes drugs. Tell us ALL medications and supplements you take.
- Certain herbs should not be used during pregnancy, breastfeeding, or with liver or kidney disease. Tell us your current health status.
- Allergic reactions are uncommon but possible. Tell us all known allergies and sensitivities.
- Herbal supplements are not FDA-regulated as prescription drugs. We use quality-assured products from trusted suppliers.

D. Important information to tell your practitioner

- A history of seizures, fainting or unusual sensations after treatment.
- Implanted electrical devices (pacemaker, spinal cord stimulator, cochlear implant, insulin pump): electrical stimulation may be contraindicated.
- Current or possible pregnancy, or plans to conceive (certain acupuncture points are contraindicated in pregnancy).
- Bleeding disorders (hemophilia, von Willebrand disease) or bruising very easily.
- Anticoagulants or daily aspirin: warfarin, heparin, Eliquis, Xarelto, Plavix, etc.
- Damaged heart valves, a history of endocarditis or a weakened immune system.
- Metal allergies (nickel, stainless steel), or allergies to adhesives, tape, oils or lotions.
- Any new symptoms or changes in your condition between appointments.

E. Statement of consent and financial agreement

I have read and understood the information above and consent to evaluation and treatment at Good Health Buena Salud Acupuncture Clinic. I understand the potential benefits and risks, and that not every complication can be anticipated or prevented. I may refuse or withdraw consent at any time without penalty. I understand cupping is NOT covered by ASH plans and agree to pay \$_____ out-of-pocket if denied. I agree to pay applicable Medi-Cal copays at the time of service. I understand my records are confidential and will not be released without written authorization except as required by law. I acknowledge receipt of the clinic's HIPAA Notice of Privacy Practices. This consent covers my entire course of treatment unless revoked in writing.

Appointment policy

A minimum of 4 hours' advance notice is required to cancel or reschedule an appointment. Late cancellations or no-shows are subject to a \$70.00 fee (not billable to insurance, due before the next visit). Repeated violations may result in discharge from the clinic. If running more than 15 minutes late, please call ahead to confirm whether your appointment can still be accommodated.

I have read and agree to sections 9 (Patient Certification) and 10 (Treatment Consent and Appointment Policy).

Patient Signature

Date

Reviewed by: _____ Date: _____

11. Arbitration Agreement

In plain language: disputes about your treatment are decided by a neutral arbitrator instead of a judge or jury. You may revoke this agreement in writing within 30 days after signing. Ask questions before signing.

NOTICE TO PATIENT: 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 HAVE A JURY OR COURT TRIAL. READ THIS AGREEMENT CAREFULLY BEFORE SIGNING.

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 California 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 also 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 backup 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 healthcare 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 all parties. Each party shall select an arbitrator (party arbitrator) within thirty (30) days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty (30) 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 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 persons or entities shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act (MICRA) 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 the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4 — General Provisions

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 therefor 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. Nothing in this agreement shall prevent either party from seeking emergency injunctive relief in a court of competent jurisdiction to prevent irreparable harm pending the outcome of arbitration.

Article 5 — Revocation

This agreement may be revoked by written notice delivered to the health care provider within thirty (30) days of signature and, if not revoked within that period, will govern all professional services received by the patient and all other disputes between the parties. Revocation must be in writing, signed by the patient, and delivered by certified mail or in person to the clinic address listed on this form. Verbal revocation will not be accepted.

Article 6 — Retroactive Effect

If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment provided prior to the completion of this form), patient should initial here: _____. If initialed, this agreement shall be effective as of the date of the first professional service rendered. 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, impaired, or invalidated by the invalidity or unenforceability of any other provision.

I HAVE READ AND UNDERSTAND THE ABOVE ARBITRATION AGREEMENT AND AGREE TO ITS TERMS.

Patient Signature

Date

12. Notice of Privacy Practices (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE IS REQUIRED BY HIPAA, 45 C.F.R. §§ 164.520.

Good Health Buena Salud Acupuncture Clinic is committed to protecting your Protected Health Information (PHI) — any information about your health condition, treatment, or payment that identifies or could reasonably identify you. This Notice describes how we may use and disclose your PHI and explains your legal rights.

I. Permitted Uses & Disclosures Without Written Authorization

- **Treatment:** To provide, coordinate, or manage your healthcare, including sharing information with other providers involved in your care (e.g., primary care physician, specialist, physical therapist), and to send appointment reminders.
- **Payment:** To obtain reimbursement for services, including submitting insurance claims, verifying eligibility, obtaining pre-authorization, and billing for services not covered by your plan.
- **Health Care Operations:** For activities needed to run the clinic and ensure quality care, including quality review, credentialing, staff training, business planning, licensing, and administrative functions.
- **As Required by Law:** We will disclose your PHI as required by federal, state, or local law, including for law enforcement, mandatory disease reporting, public health activities, audits, and lawful subpoenas or court orders.
- **Workers' Compensation:** To comply with workers' compensation laws, particularly in the event of a work-related injury or illness.
- **Serious Threats to Health or Safety:** When necessary to prevent a serious and imminent threat to your safety or that of another person or the public, disclosed only to those able to help prevent the threat.

II. Uses & Disclosures Requiring Written Authorization

Any use or disclosure not described in this Notice requires your specific written authorization, including most marketing uses, sale of your PHI, disclosure of psychotherapy notes, and other uses not described herein. You may revoke authorization in writing at any time; revocation does not apply to actions already taken in reliance on it.

III. Your Health Information Rights

- **Request Restrictions:** You may ask us to limit how we use or disclose your PHI. We must honor requests not to share information with your health plan for services you paid entirely out-of-pocket (HITECH Act). Restrictions must be in writing.
- **Confidential Communications:** You may request we contact you in a specific way or at a specific location (e.g., mail only, specific phone number). We will accommodate reasonable written requests.
- **Inspect and Copy:** You have the right to inspect and obtain copies of your PHI in our records. Written requests required. A reasonable fee may apply. We may deny access in limited circumstances, subject to your right of review.
- **Request Amendment:** If you believe your PHI is inaccurate or incomplete, submit a written amendment request with your rationale. We may deny the request if the information was not created by us, is not in our records, or is already accurate. We respond within 60 days.
- **Accounting of Disclosures:** You may request a list of certain disclosures made during the prior six years (excluding treatment, payment, and operations). First request per 12-month period is free; additional requests may incur a fee.
- **Paper Copy of This Notice:** Available upon request at any time, even if you previously agreed to receive it electronically.
- **Opt Out of Fundraising:** You may opt out of fundraising communications at any time by notifying the clinic in writing. Your care will not be affected.

IV. Our Responsibilities

We are required by law to: (1) maintain the privacy and security of your PHI; (2) provide you with this Notice; (3) notify you promptly of any breach of unsecured PHI per 45 C.F.R. §§ 164.400–414; and (4) abide by the current terms of this Notice. We reserve the right to revise our privacy practices as permitted by law; changes apply to all PHI we maintain and will be posted in the clinic and available upon request.

V. Complaints

If you believe your privacy rights have been violated, you may file a complaint with this clinic or with the HHS Office for Civil Rights at www.hhs.gov/ocr/privacy/hipaa/complaints or 1-800-368-1019 (TTY: 1-800-537-7697). You will not be retaliated against or penalized for filing a complaint, and you may never be required to waive privacy rights as a condition of receiving treatment.

VI. Contact Information

Yohan Ko, L.Ac. (Privacy Officer) | Good Health Buena Salud Acupuncture Clinic
222 N. Mountain Ave, Suite 102A, Upland, CA 91786 | (909) 272-5819 | Fax (909) 550-1579 | info@buenasalud.day

I acknowledge receipt of the Notice of Privacy Practices (HIPAA).

Patient Signature

Date