PACIFIC NATUROPATHIC
MEDICAL CENTER

Dr. Alina Moser, D.C., L.Ac.

Patient Name_____ Date of Birth_____ Gender: **M / F**

Address_____ City, State, Zip_____

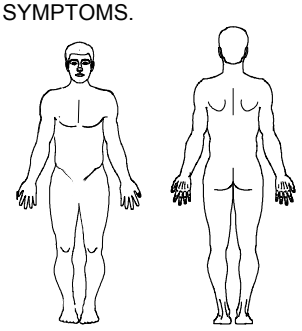
Home Phone_____ Cell Phone_____ Email_____

Occupation_____ Employer_____ Work Phone_____

Emergency Contact_____ Relationship_____ Phone_____

Height_____ Weight_____ Have you ever had acupuncture / chiropractic? **Y / N** If Yes, when?_____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain

☐ Other_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began_____

How Problem Began

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken_____ **What areas were taken?**_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____
_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Medications_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

Patient Signature_____ **Date**_____

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Additional Complaint Information:

Does the discomfort radiate/travel?

◯ Yes ◯ No

Describe the quality of the discomfort. Choose all that apply.

- ☐ Aching
- ☐ Annoying
- ☐ Burning
- ☐ Deep
- ☐ Diffuse
- ☐ Dull
- ☐ Heavy
- ☐ Intolerable
- ☐ Pulling
- ☐ Sharp
- ☐ Shock-like
- ☐ Shooting
- ☐ Stabbing
- ☐ Stiffness
- ☐ Throbbing
- ☐ Tightness
- ☐ Tingling
- ☐ OTHER

Describe the onset of the discomfort. Choose only one.

◯ Gradual ◯ Insidious ◯ Recent ◯ Spontaneous ◯ Sudden ◯ Traumatic ◯ Unknown

Describe the intensity of the discomfort. Choose only one.

◯ Mild ◯ Mild to moderate ◯ Moderate ◯ Moderate to severe ◯ Severe

What aggravates this condition? Choose all that apply.

- ☐ Almost any movement
- ☐ Athletic activity and/or exercise
- ☐ Bathing
- ☐ Bending
- ☐ Caring for family
- ☐ Carrying
- ☐ Changing positions
- ☐ Climbing stairs
- ☐ Computer use
- ☐ Concentrating
- ☐ Cooking
- ☐ Coughing and/or sneezing
- ☐ Daily child or pet care
- ☐ Driving
- ☐ Eating
- ☐ Falling or staying asleep
- ☐ Getting in or out of car
- ☐ Getting out of bed
- ☐ Getting up from lying down
- ☐ Getting up from sitting
- ☐ Grocery shopping
- ☐ Household chores
- ☐ Lifting
- ☐ Looking over shoulder
- ☐ Love life
- ☐ Lying down
- ☐ Pulling
- ☐ Pushing
- ☐ Reaching
- ☐ Reading
- ☐ Repetitive motions
- ☐ Resting
- ☐ Running
- ☐ Self care (dressing, bathing, etc.)
- ☐ Shaving
- ☐ Sitting
- ☐ Squatting
- ☐ Standing
- ☐ Stress
- ☐ Stretching
- ☐ Talking on telephone
- ☐ Turning
- ☐ Twisting
- ☐ Unknown
- ☐ Walking
- ☐ Working
- ☐ Yard work
- ☐ OTHER

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What improves this condition? Choose all that apply.

- ☐ Nothing
- ☐ Chiropractic adjustment
- ☐ Cold packs
- ☐ Exercise
- ☐ Heat packs
- ☐ Massage
- ☐ Over-the-counter medications
- ☐ Physical therapy
- ☐ Prescription medication
- ☐ Re-direct attention
- ☐ Rest
- ☐ Stretching
- ☐ Work
- ☐ OTHER

What treatment have you received for this condition up to now?

- ☐ None
- ☐ Acupuncture
- ☐ Chiropractic care
- ☐ Craniosacral therapy
- ☐ Homeopathic medicine
- ☐ Hypnosis
- ☐ Injection therapy
- ☐ Medical care
- ☐ Naturopathic medicine
- ☐ Nutritional supplements
- ☐ Occupational therapy
- ☐ Osteopathic medicine
- ☐ Over-the-counter medications
- ☐ Physical therapy
- ☐ Prescribed medications
- ☐ Psychotherapy
- ☐ Reiki
- ☐ Surgery
- ☐ OTHER

Have you ever had any previous episodes of this condition?

◯ Yes ◯ No

In what ways does this condition affect your life and your ability to function? Choose all that apply.

- ☐ Bending over
- ☐ Caring for family
- ☐ Climbing stairs
- ☐ Concentrating
- ☐ Dressing myself
- ☐ Driving a car
- ☐ Exercising
- ☐ Getting in/out of car
- ☐ Getting to sleep
- ☐ Grocery shopping
- ☐ Household chores
- ☐ Lifting objects
- ☐ Looking over shoulder
- ☐ Love life
- ☐ Lying down
- ☐ Reaching overhead
- ☐ Rising out of chair or bed
- ☐ Showering or bathing
- ☐ Sitting
- ☐ Standing
- ☐ Staying asleep
- ☐ Using a computer
- ☐ Walking
- ☐ Yard work

Do you have an additional complaint?

◯ Yes ◯ No

If Yes, please explain_____

I certify that I am the patient listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I authorize the examination and treatment of my condition as my practitioner sees fit. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand that my practitioner may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my practitioner to contact my physician, if necessary.

Patient Signature_____ **Date**_____

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Policy Agreement

Cancellation Policy:
We have a 48-business hour cancellation policy stating that we require at least 48-business hours (2-business days) advanced notice for cancellation of an appointment. This agreement is acknowledged by a credit card number on file to hold any appointments. In the event that you do not give a 48-business hour (2-business day) notice or fail to show for a scheduled appointment your credit card on file will be charged up to the full amount of the missed appointment.

Return Policy:
Supplements can only be returned if they are unopened AND if it has been less than 30 days since the product was purchased, with a receipt present. Please note that there is a 20% restocking fee for all supplements returned. Perishable supplements including probiotics and fish oils cannot be returned. *Special order supplements (supplements NOT normally carried in store) are NON REFUNDABLE and must be paid in full at time of order. Skin care products may only be returned if there was an allergic reaction to the product and if our office is notified immediately (within 1 week of the purchase date). Our skin care professional must also observe the reaction.
All returns will be in the form of an office credit, available for use towards your next purchase.

Medicare/MediCal Patients:
We regret to inform you that Medicare and MediCal are not covering any services provided by Naturopathic Doctors, including but not limited to office visits, blood work, prescriptions etc. Please be sure to check with your insurance provider regarding their policies for Naturopathic Doctors and reimbursement for office visits, as we are private pay office.

Parents:
Children need to be supervised at all times. We cannot have children running in the halls or being loud as we have spa treatments being done in our facility. You are welcome to go for a walk while waiting for your appointment if necessary.
When the fireplace is on it is very hot to the touch. If touched there is a risk of being burned. Please supervise your child at all times. By signing this policy you agree to release PNMC of any liabilities caused by failure to comply.
_____ (Initials)

Cell Phones:
Please do not use cell phones in the office. You are welcome to step outside to make or receive a call. By signing this policy agreement you consent to comply with our policies. We look forward to serving you and your healthcare needs.

PLEASE NOTE: Patients are advised to maintain continued care and follow up with their current specialist. Patients being treated for Tick Born diseases must maintain primary care, in addition to consulting with Dr. Thoring.

I have read, understand, and agree to comply with the terms of your office Policy.

_____ _____
Signature of Patient/Guardian **Date**

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Acupuncture Informed Consent To Treat

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 Alina Moser, L.Ac. and/or other licensed acupuncturists who now or in the future treat me while working or associated with or serving as back-up for Alina Moser, L.Ac., including those working at this office, 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 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 a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion. 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.

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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

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 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.

PATIENT NAME

(Please Print) (Indicate relationship if signing for patient)

(DATE)

PATIENT SIGNATURE

(Or Patient Representative) (Indicate relationship if signing for patient)

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures.

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

PATIENT NAME
(Please Print) (Indicate relationship if signing for patient)

(DATE)

PATIENT SIGNATURE
(Or Patient Representative) (Indicate relationship if signing for patient)