



Acupuncture & Chinese Herb Clinic
2111 Dickson Dr. Suite 26 Austin, TX. 78704
512 899 8996

Thank You for coming. Please help us provide you with the best possible treatment plan by completing this form. If you have any questions, please ask.
All your information is absolutely confidential
Thank you!

Personal Information:

Name _____ Date: _____

Home Address: _____

City/ State/ Zip: _____

Home Phone: (____) _____ Cell/ Work:(____) _____

Email: _____

Occupation: _____ Employer: _____

Sex: [] F [] M Height: _____ Weight: _____ lbs.

Birth day: _____ Age: _____

DL#: _____

Marital Status: M S D W Number of Children: _____

How did you find out about our office? _____

Supplements (vitamins, herbs, minerals, etc.): _____

Person Responsible for Your Account: _____

Have you received Acupuncture before? Yes No

Major Complaint(s), in order of significance to you:

Table with 4 columns: Severe, Moderate, Slight, Normal. Rows 1-4 for complaint details.

How do these conditions impair your daily activities?

Other physicians/ therapists seen for this condition: _____

Treatment:

Results:

Recent Therapies for the conditions stated above: (including Western Drug, Massage, Chiropractic, etc)

SYMPTOM SURVEY FORM

PATIENT _____ DOCTOR _____ DATE _____

INSTRUCTIONS: Number the boxes which apply to you. Use (1) for MILD symptoms (occur once or twice every couple months- year), (2) for MODERATE symptoms (occur several times a month), and (3) for SEVERE symptoms (you are aware of it almost constantly).

GROUP ONE

- | | | | | | |
|----------------------------|-------------------------|-----------------------------|----------------------------------|-----------------------------|------------------------|
| 1 <input type="checkbox"/> | Acid foods upset | 8 <input type="checkbox"/> | Gag easily | 15 <input type="checkbox"/> | Appetite reduced |
| 2 <input type="checkbox"/> | Get chilled, often | 9 <input type="checkbox"/> | Unable to relax; startles easily | 16 <input type="checkbox"/> | Cold sweats often |
| 3 <input type="checkbox"/> | "Lump" in throat | 10 <input type="checkbox"/> | Extremities cold, clammy | 17 <input type="checkbox"/> | Fever easily raised |
| 4 <input type="checkbox"/> | Dry mouth-eyes-nose | 11 <input type="checkbox"/> | Strong light irritates | 18 <input type="checkbox"/> | Neuralgia-like pains |
| 5 <input type="checkbox"/> | Pulse speeds after meal | 12 <input type="checkbox"/> | Urine amount reduced | 19 <input type="checkbox"/> | Staring, blinks little |
| 6 <input type="checkbox"/> | Keyed up – fail to calm | 13 <input type="checkbox"/> | Heart pounds after retiring | 20 <input type="checkbox"/> | Sour stomach frequent |
| 7 <input type="checkbox"/> | Cuts heal slowly | 14 <input type="checkbox"/> | "Nervous stomach" | | |

GROUP TWO

- | | | | | | |
|-----------------------------|--|-----------------------------|------------------------------------|-----------------------------|--------------------------------------|
| 21 <input type="checkbox"/> | Joint stiffness after arising | 29 <input type="checkbox"/> | Digestion rapid | 37 <input type="checkbox"/> | "Slow starter" |
| 22 <input type="checkbox"/> | Muscle-leg-toe cramps at night | 30 <input type="checkbox"/> | Vomiting frequent | 38 <input type="checkbox"/> | Get "chilled" infrequently |
| 23 <input type="checkbox"/> | "Butterfly" stomach, cramps | 31 <input type="checkbox"/> | Hoarseness frequent | 39 <input type="checkbox"/> | Perspire easily |
| 24 <input type="checkbox"/> | Eyes or nose watery | 32 <input type="checkbox"/> | Breathing irregular | 40 <input type="checkbox"/> | Circulation poor, sensitive to cold |
| 25 <input type="checkbox"/> | Eyes blink often | 33 <input type="checkbox"/> | Pulse slow; feels "irregular" | 41 <input type="checkbox"/> | Subject to colds, asthma, bronchitis |
| 26 <input type="checkbox"/> | Eyelids swollen, puffy | 34 <input type="checkbox"/> | Gagging reflex slow | | |
| 27 <input type="checkbox"/> | Indigestion soon after meals | 35 <input type="checkbox"/> | Difficulty swallowing | | |
| 28 <input type="checkbox"/> | Always seems hungry; feels "lightheaded" often | 36 <input type="checkbox"/> | Constipation, diarrhea alternating | | |

GROUP THREE

- | | | | | | |
|-----------------------------|--------------------------------|-----------------------------|--|-----------------------------|---|
| 42 <input type="checkbox"/> | Eat when nervous | 49 <input type="checkbox"/> | Heart palpitates if meals missed or delayed | 53 <input type="checkbox"/> | Crave candy or coffee in afternoons |
| 43 <input type="checkbox"/> | Excessive appetite | 50 <input type="checkbox"/> | Afternoon headaches | 54 <input type="checkbox"/> | Moods of depression – "blues" or melancholy |
| 44 <input type="checkbox"/> | Hungry between meals | 51 <input type="checkbox"/> | Overeating sweets upsets | 55 <input type="checkbox"/> | Abnormal craving for sweets or snacks |
| 45 <input type="checkbox"/> | Irritable before meals | 52 <input type="checkbox"/> | Awaken after few hours sleep – hard to get back to sleep | | |
| 46 <input type="checkbox"/> | Get "shaky" if hungry | | | | |
| 47 <input type="checkbox"/> | Fatigue, eating relieves | | | | |
| 48 <input type="checkbox"/> | "Lightheaded" if meals delayed | | | | |

GROUP FOUR

- | | | | | | |
|-----------------------------|---|-----------------------------|---|-----------------------------|---|
| 56 <input type="checkbox"/> | Hands and feet go to sleep easily, numbness | 63 <input type="checkbox"/> | Get "drowsy" often | 68 <input type="checkbox"/> | Bruise easily, "black and blue" spots |
| 57 <input type="checkbox"/> | Sigh frequently, "air hunger" | 64 <input type="checkbox"/> | Swollen ankles worse at night | 69 <input type="checkbox"/> | Tendency to anemia |
| 58 <input type="checkbox"/> | Aware of "breathing heavily" | 65 <input type="checkbox"/> | Muscle cramps, worse during exercise; get "charley horses" | 70 <input type="checkbox"/> | "Nose bleeds" frequent |
| 59 <input type="checkbox"/> | High altitude discomfort | 66 <input type="checkbox"/> | Shortness of breath on exertion | 71 <input type="checkbox"/> | Noises in head, or "ringing in ears" |
| 60 <input type="checkbox"/> | Opens windows in closed room | 67 <input type="checkbox"/> | Dull pain in chest or radiating into left arm, worse on exertion. | 72 <input type="checkbox"/> | Tension under the breastbone, or feeling of tightness" worse on exert |
| 61 <input type="checkbox"/> | Susceptible to colds and fevers | | | | |
| 62 <input type="checkbox"/> | Afternoon "yawner" | | | | |

- 73 Dizziness
- 74 Dry Skin
- 75 Burning feet
- 76 Blurred vision
- 77 Itching skin and feet
- 78 Excessive falling hair
- 79 Frequent skin rashes
- 80 Bitter, metallic taste in mouth in mornings
- 81 Bowel movements painful or difficult
- 82 Worrier, feels insecure

GROUP FIVE

- 83 Feeling queasy; headache over eyes
- 84 Greasy foods upset
- 85 Stools light-colored
- 86 Skin peels on foot soles
- 87 Pain between shoulder blades
- 88 Use laxatives
- 89 Stools alternate from soft to watery
- 90 History of gallbladder attacks or gallstones

- 91 Sneezing attacks
- 92 Dreaming, nightmare type bad dreams
- 93 Bad breath (halitosis)
- 94 Milk products cause distress
- 95 Sensitive to hot weather
- 96 Burning or itching anus
- 97 Crave sweets

- 98 Loss of taste for meat
- 99 Lower bowel gas several hours after eating
- 100 Burning stomach sensations, eating relieves

GROUP SIX

- 101 Coated tongue
- 102 Pass large amounts of foul-smelling gas

- 103 Indigestion ½ - 1 hour after eating; may be up to 3 - 4 hrs.
- 104 Mucous colitis or "irritable bowel"
- 105 Gas shortly after eating
- 106 Stomach "bloating" after eating

- (A)**
- 107 Insomnia
 - 108 Nervousness
 - 109 Can't gain weight
 - 110 Intolerance to heat
 - 111 Highly emotional
 - 112 Flush easily
 - 113 Night sweats
 - 114 Thin, moist skin
 - 115 Inward trembling
 - 116 Heart palpitates
 - 117 Increased appetite without weight gain
 - 118 Pulse fast at rest
 - 119 Eyelids and face twitch
 - 120 Irritable and restless
 - 121 Can't work under pressure
- (B)**
- 122 Increase in weight
 - 123 Decrease in appetite
 - 124 Fatigue easily
 - 125 Ringing in ears
 - 126 Sleepy during day
 - 127 Sensitive to cold
 - 128 Dry or scaly skin
 - 129 Constipation
 - 130 Mental sluggishness
 - 131 Hair coarse, falls out
 - 132 Headaches upon arising wear off during day
 - 133 Slow pulse, below 65
 - 134 Frequency of urination
 - 135 Impaired hearing
 - 136 Reduced initiative

GROUP SEVEN

- (C)**
- 137 Failing memory
 - 138 Low blood pressure
 - 139 Increased sex drive
 - 140 Headaches, "splitting or rending" type
 - 141 Decreased sugar tolerance
- (D)**
- 142 Abnormal thirst
 - 143 Bloating of abdomen
 - 144 Weight gain around hips or waist
 - 145 Sex drive reduced or lacking
 - 146 Tendency to ulcers, colitis
 - 147 Increased sugar tolerance
 - 148 Women: menstrual disorders
 - 149 Young girls: lack of menstrual function

- (E)**
- 150 Dizziness
 - 151 Headaches
 - 152 Hot flashes
 - 153 Increased blood pressure
 - 154 Hair growth on face or body (female)
 - 155 Sugar in urine (not diabetes)
 - 156 Masculine tendencies (female)
- (F)**
- 157 Weakness, dizziness
 - 158 Chronic fatigue
 - 159 Low blood pressure
 - 160 Nails weak, ridged
 - 161 Tendency to hives
 - 162 Arthritic tendencies
 - 163 Perspiration increase
 - 164 Bowel disorders
 - 165 Poor circulation
 - 166 Swollen ankles
 - 167 Crave salt
 - 168 Brown spots or bronzing of skin
 - 169 Allergies - tendency to asthma
 - 170 Weakness after colds, influenza
 - 171 Exhaustion - muscular and nervous
 - 172 Respiratory disorders

GROUP 8

- | | | | | | |
|-----|--------------------------|--|-----|--------------------------|--|
| 173 | <input type="checkbox"/> | Apprehension | 186 | <input type="checkbox"/> | Hair is Coarse and/or thinning |
| 174 | <input type="checkbox"/> | Irritability | 187 | <input type="checkbox"/> | Weakness |
| 175 | <input type="checkbox"/> | Morbid fears | 188 | <input type="checkbox"/> | Fatigue |
| 176 | <input type="checkbox"/> | Never seems to get well | 189 | <input type="checkbox"/> | Skin sensitive to touch |
| 177 | <input type="checkbox"/> | Forgetfulness | 190 | <input type="checkbox"/> | Tendency towards hives |
| 178 | <input type="checkbox"/> | Indigestion | 191 | <input type="checkbox"/> | Nervousness |
| 179 | <input type="checkbox"/> | Poor appetite | 192 | <input type="checkbox"/> | Headache |
| 180 | <input type="checkbox"/> | Craving for sweets | 193 | <input type="checkbox"/> | Insomnia |
| 181 | <input type="checkbox"/> | Muscular soreness | 194 | <input type="checkbox"/> | Anxiety |
| 182 | <input type="checkbox"/> | Depression/ Feeling something dreadful | 195 | <input type="checkbox"/> | Anorexia |
| 183 | <input type="checkbox"/> | Noise sensitivity | 196 | <input type="checkbox"/> | Inability to concentrate or Confusion |
| 184 | <input type="checkbox"/> | Acoustic hallucinations | 197 | <input type="checkbox"/> | Frequent stuffy nose / sinus infection |
| 185 | <input type="checkbox"/> | Tendency to cry without reason | 198 | <input type="checkbox"/> | Allergy to some foods |
| | | | 199 | <input type="checkbox"/> | Loose Joints |

FEMALE ONLY

- | | | | | | |
|-----|--------------------------|--|-----|--------------------------|------------------------------|
| 200 | <input type="checkbox"/> | Very easily fatigued | 208 | <input type="checkbox"/> | Hysterectomy/ovaries removed |
| 201 | <input type="checkbox"/> | Premenstrual tension | 209 | <input type="checkbox"/> | Menopausal hot flashes |
| 202 | <input type="checkbox"/> | Painful menses | 210 | <input type="checkbox"/> | Menses scanty or missed |
| 203 | <input type="checkbox"/> | Depressed feelings before menstruation | 211 | <input type="checkbox"/> | Acne, worse at menses |
| 204 | <input type="checkbox"/> | Menstruation excessive | 212 | <input type="checkbox"/> | Depression of long standing |
| 205 | <input type="checkbox"/> | Painful breasts | | | |
| 206 | <input type="checkbox"/> | Menstruate too frequently | | | |
| 207 | <input type="checkbox"/> | Vaginal discharge | | | |

Women Only:

Regular menstrual cycle? Y N Pregnant? Y N
 Number of Children: _____ Number of pregnancies: _____
 Age of first menstruation: _____ Age of menopause(if applicable) _____
 Average number of days of flow: _____ Average number of days of entire cycle: _____

	Severe	Moderate	Slight	Normal
Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Between periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you experience any of the following?

Nausea Food Craving Depression Vomiting Headaches Irritability

Water retention Migraines Anxiety Breast tenderness

Other emotions: _____ Dull Pain, Where? _____

Sharp Pain, Where? _____

Other: _____

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color: (normal, pale, bright red, rust, dark, other)							
Amount of flow: (normal, heavy, light)							
Pain/Cramps: (location, dull, sharp, other)							
Clots: (large, small, black, purple, red, other)							
Nausea							
Vomiting							
Other							

MALE ONLY

- 186 Prostate trouble
- 187 Urination difficulty or dribbling
- 188 Night urination frequent
- 189 Depression
- 190 Pain on inside of legs or heels
- 191 Feeling of incomplete bowel evacuation
- 192 Lack of energy
- 193 Migrating aches and pains
- 194 Tire too easily
- 195 Avoids activity
- 196 Leg nervousness at night
- 197 Diminished sex drive

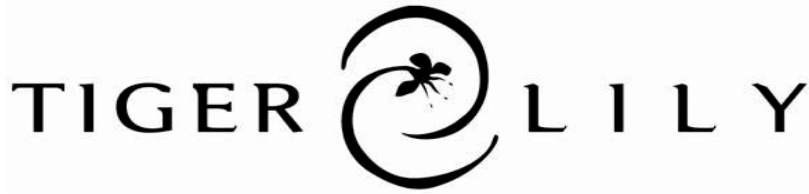
Men only:

	Severe	Moderate	Slight	Normal
<input type="checkbox"/> Swollen Testes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Testicular Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Impotence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Premature ejaculation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Feeling of coldness or numbness in external genitalia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other comments: _____

Patient signature: _____

Acupuncturist Signature: _____



Acupuncture & Chinese Herbal Clinic

Acknowledgement Form

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I acknowledge that TigerLily Acupuncture and Chinese Herbal Clinic's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review TigerLily Acupuncture and Chinese Herbal Clinic's "Notice of Privacy Practices" prior to signing this document. TigerLily Acupuncture and Chinese Herbal Clinic's "Notice of Privacy Practices" has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information that will occur in my treatment, payment of my bills or in the performance of health care operations of TigerLily Acupuncture and Chinese Herbal Clinic. The Notice of Privacy Practices for TigerLily Acupuncture and Chinese Herbal Clinic is also provided on request at the front desk of this practice and on TigerLily Acupuncture and Chinese Herbal Clinic's website at www.tigerlilyacupuncture.com. This Notice of Privacy Practices also describes my rights and TigerLily Acupuncture's duties with respect to my Protected Health Information.

TigerLily Acupuncture and Chinese Herbal Clinic reserve the right to change the privacy practices that are described in the "Notice of Privacy Practices". I may obtain a revised notice of privacy practices by calling TigerLily Acupuncture and Chinese Herbal Clinic's office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

Name of Patient or Personal Representative (Print)

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Douglas Rutkowski, LAc.

April 14, 2005

Name of Privacy Officer

Date



Acupuncture & Chinese Herb Clinic
2111 Dickson suite 26 Austin, TX. 78704
512 899-8996

Notification Form Regarding Evaluation of Patient by Physician

(Pursuant to the requirement of section 183.6(e) of the title and section 6.11, Subsection (d) V. A. C. article 44956b, governing the practice of acupuncture)

I (patient's name), _____ am
notifying TigerLily Acupuncture and Chinese Herbal Clinic of the following:

Yes__ No__ I have been evaluated by a physician, dentist, or nurse practitioner, for the condition being treated within twelve (12) months before the acupuncture was performed. I recognize that a physician should evaluate me for the condition being treated by the acupuncturist.

OR

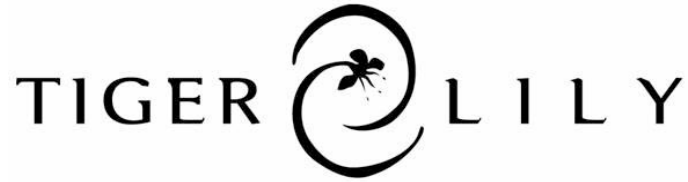
Yes__ No__ I have received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is _____, and the most recent date of chiropractic treatment prior to acupuncture treatment is _____. After being referred by a chiropractor, if after 120 days or 30 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice to follow his advice.

Patients Signature (required) _____ Date _____

The Acupuncturist has referred me to a physician. It is my responsibility and choice to follow her/his advice.

Patients Signature (required) _____ Date _____

Acupuncturist's Signature _____ Date _____



Acupuncture & Chinese Herb Clinic
2111 Dickson Dr suite 26
Austin, TX 78704

PATIENT INFORMATION

Appointments:

Treatments are by appointment only. If you find that you need to cancel an appointment, it is important that we receive twenty-four (24) hour notice. This enables us to fill the time slot. We reserve the right to charge a \$75.00 fee for appointments canceled with less than twenty-four hour notice or for “no show” appointments.

Payment for Services Rendered

Payment is due at time of service and may be paid in *cash, check, MasterCard or Visa*. We do *not* bill for services rendered.

Herbal Refills

If you require a refill on an herbal formula prescribed during a previous treatment, we encourage you to make a follow-up appointment to determine if the formula is still appropriate for your current needs.

Insurance

We would be happy to file your claims for you. Please indicate if you have insurance before your appointment begins so that we can copy your insurance card and check your benefits. If you have benefits for acupuncture, we will give you a clear explanation of your benefits, including number of visits/year, co-pay & deductible.

Please sign and date on the line provided below. Thank you for allowing us to provide you with a quality, low-cost alternative to traditional health care.

Patient's Signature

Date



Acupuncture & Chinese Herb Clinic
2111 Dickson Dr. Suite 26 Austin, TX. 78704

Patient Name: _____

Arbitration Agreement

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 state and federal law, and not by 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 to 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 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 intended to bind the patient and the health care provider and/or other licensed health care providers or preceptors interns who now or in the future treat the patient while employed by, working or associated with or serving as a 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 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 should 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 thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay each party's pro rata share of the expenses and fees of 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 person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgement for future damages conformed to periodic payments, shall apply to disputes within this arbitration agreement. The parties further agree that 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 that the notice is thereof received, the claim, if asserted in 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.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 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 the patient intends this agreement to cover services rendered before the date 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 DECIDE BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY IN A COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE _____ DATE _____

OFFICE SIGNATURE _____ DATE _____



Acupuncture & Chinese Herb Clinic
2111 Dickson suite 26 Austin, TX. 78704
512 899-8996

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 the acupuncture on me (or on the patient named below, for whom I am legally responsible) by Douglas Rutkowski and/or Vanessa Rutkowski, including those working at the clinic or 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 limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (chinese massage), Chinese herbal medicine, nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is 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. 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 potential risk of moxibustion and cupping. I understand that while this document describes the major risks of 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 a large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effect 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.

I do not expect the clinical staff to be able 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 the treatment which the clinical staff thinks at the time, based upon the facts known to my best interest. I understand the 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 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 I 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 _____