PATIENT NAME:	**REFERRED BY**
ADDRESS SS#:	HOME PHONE CELL EMAIL OCCUPATION: IN CASE OF EMERGENCY NOTIFY:

DOB: HEIGHT: WEIGHT:

DESCRIBE YOUR COMPLAINT:

Please rate the extent to which your current complaint affects your daily life (1 = minor: 10 = major)
What other forms of treatment have you sought?

WHAT WAS DIAGNOSED BY MD?

How did you find out about us?

MEDICATIONS, VITAMINS OR HERBS:	WHAT FOR:

Tendency To Be **Cold/Warm/Normal** Afternoon Fever/ Night Fever Aversion To Cold Or Heat ☐Both ☐Alternate	**Sleep**: ☐Good ☐Y 5/6/7/8/9hrs A Day ☐N: ☐Difficult To Fall Asleep/ ☐Easily Awake/ ☐Dreaming/☐Insomnia ☐Restlessness ☐Always Feel Sleepy Time To Go To Bed ___Pm/Am Time To Get Up ____ Am/Pm	**Defecation**: Norm ☐Y ☐N Formed ☐Y ☐N Dry ☐Y ☐N Difficult BM ☐Y ☐N _____Times A Day Once/Every Other Day /2 Days/3 Days Or __ Days Painful/Itchy/Bloody/Loose/Watery/ Unpredictable/Other
Sweating: ☐Y ☐N ☐ Day ☐ Night ☐ Sometimes ☐ Always Whole Body Head Neck Palms		
Pain ☐ Y ☐ N ☐Body ☐Arm ☐Hand ☐Leg ☐Foot ☐Heachache: ☐Frontal ☐Temporal ☐Vertex ☐Occipital	**Appetite**: ☐Normal/☐Poor/☐Hyper/☐Easily Hunger ☐Desire Or ☐No Desire For Food	**Menses**: Menopause ☐Y ☐N Bleeding ___Days Normal/Excessive/Scanty Color: Red/Dark Red/Light/Brown Blood Clots: ☐ Y ☐N Pain: Before Menses/During/After Pregnancy ☐Y ☐N Pregnant ___Times Give Birth____ Times Miscarriage_____Times. Abortions____ Birth Control: ☐Y ☐N ☐Pills ☐Condom ☐Other
Dizzy ☐Y ☐N ☐Often ☐Sometimes ☐Rare ☐Chest ☐Pressing ☐Palpitations	**Taste**: Norm ☐Y ☐N ☐No Taste Sweet/Sour/Bitter/Salty/Spicy	
Ear: ☐Normal ☐Tinnitus ☐Deafness ☐Auditory	**Digestion**: ☐Normal ☐Distention/☐Nausea ☐Belching/☐Hiccup ☐Bad Breath/☐Burning ☐Acid Reflux ☐Always After A Meal ☐When Hungry	
Eyes: ☐Normal/☐Itchy/☐Teary ☐Burning ☐Painful ☐Swollen ☐Dry ☐Dim ☐Eyesight ☐Near-Sighted ☐Far-Sighted ☐Other		**Energy** From 1-10 Steady/ Up/Up And Down/Down_ **Lifestyle/Emotions**: Normal ☐Stress ☐Emotions ☐Other
Thirst: ☐Y ☐N ☐Cold Water ☐Hot Water ☐Room Temp. Water ___Oz A Day ☐ No Desire To Drink	**Urination**: Light Yellow And Clear ☐Y ☐N ☐ Frequent ☐Difficult ☐ Lg Amounts ☐Scanty & Dark/☐Cloudy/☐Pain ☐Urgent ☐Burning ☐Dribbling ☐Incontinence Wake Up To Urinate At Night Times	

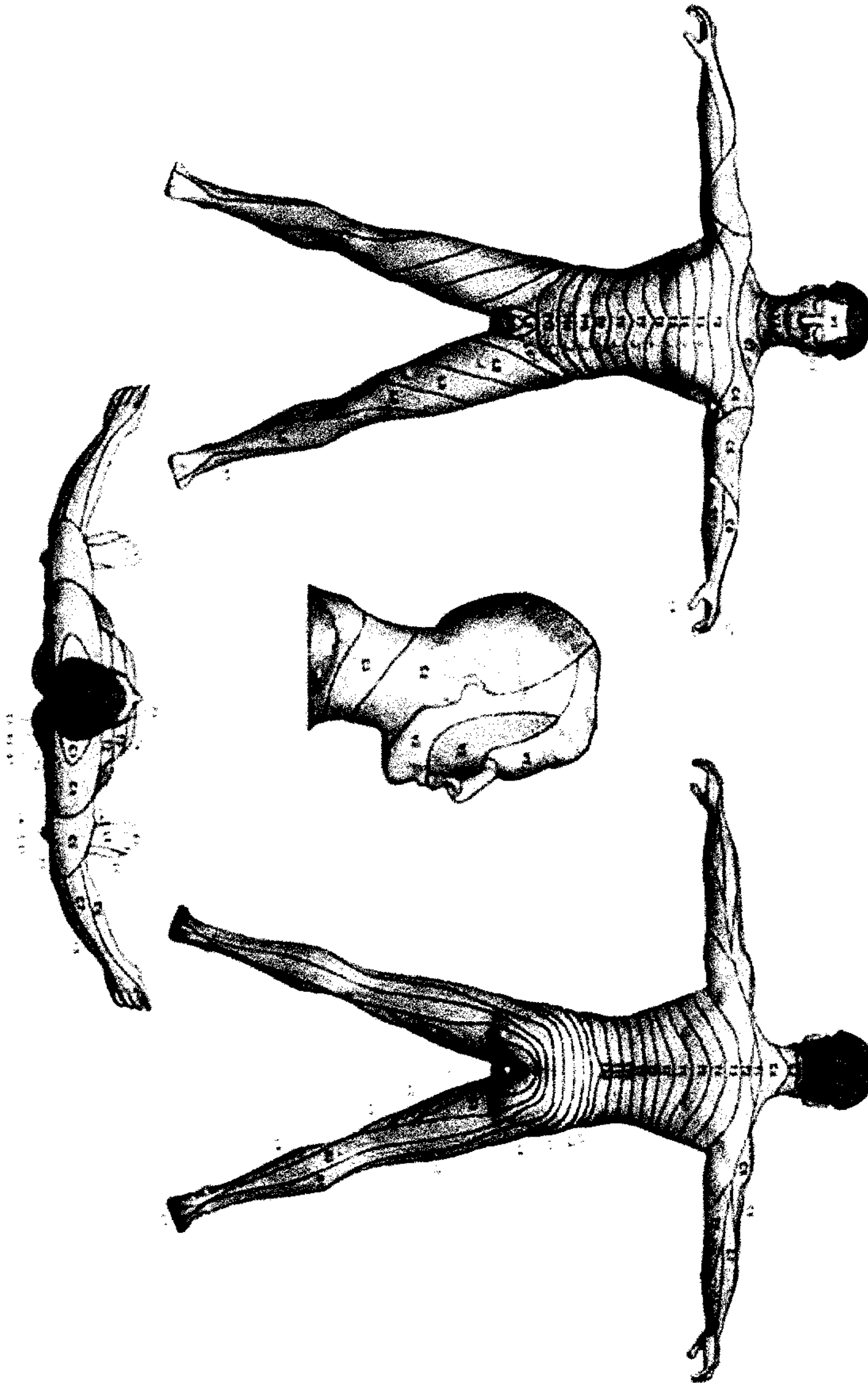
PAST EDICAL HISTORY (check all which apply)
ANY SURGERIES OR ACCIDENTS?
CHILDHOOD:

ADOLESCENCE:
ADULTHOOD:

Major Illnesses In Your Immediate Family, Like Diabetes, Heart Disease, Blood Pressure, Neurological Disorders, Psychological Disorders, Blood Disorders, Orthopedic Disorders Etc.

Circle Any Problem, Disease Or Symptom That You Have Now.

Skin: Eczema Acne Skin Rash Dermatitis Furuncles Fungal Infections Warts Psoriasis
Cardiovascular: Fast Pulse (Over 100 Bpm) Slow Pulse (Less Than 60 Bpm) Palpitations Irregular Pulse Feeling Pressure In The Chest Short Of Breath Chest Pain Dizziness Migraine Headache With Nausea Cold Hands Cold Feet Reynauld's Disease (Circulation Problems) Flushed Face Anemia High Blood Pressure Low Blood Pressure Cold Sweats Red Face Feel Dizzy Or Faint When Standing Up Quickly Or Standing For A Long Time
Respiratory: Asthma Bronchitis Emphysema Cough Wheezing Pneumonia Lung Abscess
Hormonal Imbalance: Low Thyroid Overactive Thyroid Diabetes Hypoglycemia Blood Sugar Other Hormonal Imbalances
Male: Impotence Premature Ejaculation Prostate Gland Problem Vasectomy Infertility
Female: Menstrual Problems Cramping Heavy Or Light Or Irregular Period PMS Emotional Reactions Menopause Symptoms Tubal Litigation Infertility Low Libido Painful Menses Irregular Menses Premenstrual Symptoms Strong Menstrual Odor Vaginal Discharge/Odor Vaginal Dryness Fibroids Breast Lumps/Swellings Endometriosis Ovarian Cysts Sexually Transmitted Disease Urinary Tract Infection Hot Flashes Decreased Sex Drive Positive Mammogram/Pap Smear Other (Please Specify)
Neurological: Seizures Dizziness Loss Of Balance Areas Of Numbness Poor Memory Lack Of Coordination Concussion
Autoimmune And Inflammatory Conditions: Hasimoto's Disease Rheumatism Systemic Lupus Erythematosus Colitis Crohn's Disease Alopecia (Boldness) Allergy Food Allergy Atopic Dermatitis Neurodermatitis Celulitis Sinus Allergies Low Immunity Cancer Diabetes
Effects Of Focal Infections: Rheumatic Disease, Rheumatic Fever Arthritis Skin Disease Connective Tissue Or Ligament Disease
Myofascial Pain Fibromyalgia Tendonitis Ligaments Pericarditis Constant Slight Fever Glomerulonephritis Plantar Fasciitis Scarlet Fever Ear Infections Streptococci Infections Staphylococci Infections Easily Catch Cold Or Sore Throat Swollen Glands
Ear Nose And Throat: Deafness Tinnitus (Ringing In The Ear) Itchy Ear Ear Pain Frequent Ear Infections Sinus Headaches Yellow Mucus Stuffy Nose Post Nasal Drip Dry Throat Itchy Throat Constant Sinus Congestion Strep Throat Infections Sore Throat
Oral Disease: Bleeding Gums Periodontitis Dental Abscess Mumps Stomatitis TMJ Toothaches Without Cavities
General: Insomnia Psychosomatic Weakness Exhaustion Emotional Problems (Anger, Irritability, Depression, Anxiety) Difficulty Concentrating On A Task Easily Get Car Sick Sea Sick Air Sick No Appetite For Breakfast Moody In The Morning Unusual Sweating (Palm - Sole - Elsewhere)
Before Noon Time: No Energy Feeling Spacey Scattered-Minded Energetic All Evening Through Midnight But Hate To Wake Up Early In The Morning Long Shower Or Bath Makes You Feel Dizzy Or Faint.
Emotional Disorders Depression OCD Anxiety Bad Temper Easily Stressed Attempted Suicide Treated For Emotional Problems (Please Specify) In Infancy Or Childhood Have You Ever Been: Neglected Abandoned Physically Abused Emotionally Abused Sexually Abused Separated From Your Family Birth Trauma? At Any Other Point In Your Life Have You Ever Been: Emotionally Abused Physically Abused Sexually Abused Victim Of A Crime Divorced/Widowed Other Trauma (Please Describe) Other Abuse (Please Describe)
Medications And Drugs: Birth Control Pill Cigarettes Alcohol Cocaine Marijuana
ANY SCARS ON THE BODY?



Please shade the areas where you feel pain.

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 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 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 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 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 all parties. 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 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 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 law, 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 judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. 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 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 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 A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

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

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 the acupuncturist named below 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 the acupuncturist named below, 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 not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and 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 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 and cupping, or when treatment involves the use of heat lamps. 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.

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 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.

	(Date)
PATIENT SIGNATURE **X**	

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

Healing Art of Acupuncture
Irina Kozina, L.Ac.
77 Longfellow Avenue Piscataway NJ 08854
Tel. (917) 617-6779 eFax. (206) 337-9618
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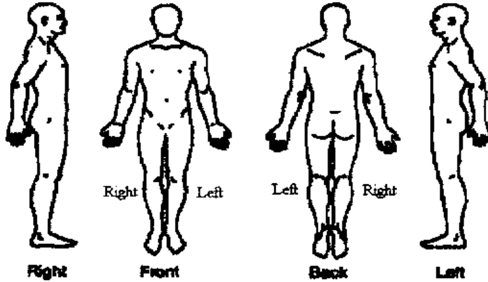
Re evaluation report

Patient's name:____________________ **M F DOB** ________________
DOA____________________________ **Exam Date** ______________________

Subjective/Chief Complaint:

Nature of injury: ☐ DMV: ☐ work injury ☐acupuncture for maintenance care ☐myofascial pain
If MVA: Pt was ☐A Driver ☐Passenger ☐Pedestrian
Pt Was ☐ taken to the hospital ☐ went home
Impact From The ☐Rear ☐Left ☐Right ☐Front



Subjective: Patient states that the degree of pain/discomfort in the following areas on the scale from 10 to 0 (10= severe pain; 5=moderate pain;0=no pain) is as follows - Column 1:

Zones/Zang-Fu affected: YangMing-TaiYang-ShaoYang/

Objective: ROM is found to be as follows (Columns 2,3,4):

Pain location; pain index 1-10	Flexion/Extension	Rotation L/R	Bending, Abduction
Neck:L / R / B	N=60/75	N=80/80	N=45/45
LB:L / R / B	N=60/75	N=80/80	N=45/45
Elbow:L / R / B	N=150	N=80/80	
Wrist:L / R / B	N=80/70	N=20/30	
Hip: L / R / B	N=100/30	N=40/20	N=45145
Knee:L / R / B	N=130		
Ankle:L / R / B	N= 20	N=45	
Shoulder:L / R / B	N=180/60	N=180/50	N=70190

1. Headache: constant / intermittent on yangming/taiyang/shaoyang zones; dizziness, blurred vision.
☐Head injury/☐loss consciousness during the accident, since then patient has headache and dizziness.

Past medical history: ____________________________________

Objective/Physical examination:
The patient underwent a thorough physical examination and appeared to be well developed and nourished. There are sprain/strain, pain/numbness, and muscle spasms/ trigger points as a result of Qi and Blood stagnation on the neck, MB, LB, shoulder, elbow, wrist, fingers, hip/thigh, knee, ankle, foot. Pain aggravated by movements. Active and passive range of motion is restricted in flexion, extension, bending.

1. There were strain/sprain cervical/ thoratic/ lumbosacral muscles and ligaments.
2. Active/passive ROM moderately/severely restricted in flexion, extension, bending and rotation at cervical/lumbar spine, shoulder, elbow, wrist, hip, knee, ankle due to pain and stiffness.
3. Pain aggravated by movements.

Energy level: High Medium Low at morning-day-night time. **Ancillary conditions:** anxiety, stress, insomnia, depression.

Pulse: ____ b/min Quality: floating-sinking, slow-rapid, empty-full, weak-strong, tight-wiry-Soft
Tongue: Shape (thin-swollen/toothmarks-flaccid-cracked-quivering-deviated) Color (pale-red-purple-blue) Coating (thick-thin-absent/yellow-white-grey-black)Moisture (wet-dry-sticky)

TCM Diagnosis;

Clinical diagnosis:
Based upon the subjective complaints of the patient and objective examination findings, the patient appears to present the following clinical picture:

784.0 Headache	719.41 Shoulder pain
723.1 Neck pain	719.42 Elbow pain
723.2 MB pain	719.44 Hand pain
723.4 LB pain	728.85 Muscle spasm
719.45 Hip pain	716.90 Arthritis
719.46 Knee pain	724.3 Sciatic
719.47 Ankle/Foot pain	729.2 Neuralgia/Neuritis

Remarks and treatment protocol
The patient was educated of the importance of Traditional Chinese Medicine and after discussion agreed on the treatment plan. Presently, patient is suffering from post-traumatic Bi-syndrome. Beside the specific areas of pain/ discomfort described above, the patient's Qi and Blood circulation are impaired due to extreme physical and mental stress, in turn, causing severe energy disbalance. Acupuncture is going to be used to reestablish the normal function of the areas mentioned above. To promote blood and Qi circulation cupping, gua sha, shiatsu are indicated. For more pain relief UV-IR lamp, electrical stimulation, moxa are indicated.

Rendered today:
99201 Self limit Initial Consultation 99203 30min Initial Consultation
99202 20 min Initial Consultation

Treatment plan: _____times a week for _____ weeks

97813 Acupuncture,, one or more needles with electrical stimulation, initial 15 min of personal one-to-one contact with the patient.
97814 Each additional 15 minutes, acupuncture with electrical stimulation, of personal one-to-one contact with the patient with re-insertion of needles.
97026 Infrared therapy 97139 Cupping
99211-25 5 min re-evaluation 99212-25 10 min re-evaluation

Method of threatment: gua sha, tuina. Bleeding, moxa, heat, shiatsu
Needles: 0.5", 1", 1.5", 2"

Prognosis: Good / Fair / Guarded / Poor

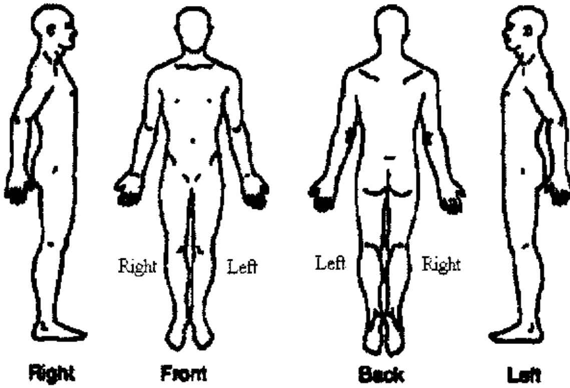
Licensed Acupuncturist Irina Kozina, L.Ac.

SOAP NOTES

Healing Art of Acupuncture, Inc, 756 Rt 15 S Suite 2B, Irina Kozina, L.Ac., License 25MZ00063000

1. **Date:**_________ **Initial Evaluation** **Follow Up**

Subjective/Objective Complaints:



ICD9 Diagnostic Code **M54.5** **M54.2**

Tongue: Purple-range-blue-white-gray-cracked-toothmarks Coating: yellow-White-Wet-dry-sticky-brown

Pulse:______ **BPM**
Rapid-Slow-Deep-Superficial-Thin/Thready/Weak-Forceful-Wiry Slippery-Intermittent-Knotted-Empty

DX & TX plan:________________________
Tai Yang -Shao Yang- Yang Ming

Point Selection:

1st 15 min________________________________

2nd 15 min________________________________

3rd 15 min________________________________

Trigger point release___________________ **10 min**

_______________________**5 min** _______________________**5 min**

Modality : Infrared Myofascial release/Gua Sha Massage Cupping E-Stim

Time needles retained:_______**Number of Needles inserted:**________

CPT code 97810 97811 97813 97814 99203 99213 97026 97140 97124 97039

Progress notes:

No change

Minimal progress, slower than expected

Progress as expected

Prognosis: **Good** **Fair** **Guarded**

Comments:

I.Kozina, L.Ac.,
Date:

Healing Art of Acupuncture NJ License 25MZ00063000
T. (917) 617-6779 F. (206) 337-9618 irina@healingartofacupuncture.com

Acupuncture progress notes

Patient's name______________________ Date____________________________

HA	LB	MB	UB	Shoulder	Elbow	Wrist	Arm	Hip	Knee	Ankle/Foot	Time needles were in place	Type of needles

___97810 acupuncture, one or more needles without electrical stimulation, initial 15 minutes of personal one-to-one contact with the patients

___97811 each additional 15 minutes, acupuncture, one or more needles without electrical stimulation, initial 15 minutes of personal one-to-one contact with the patients with re-insertion of needles

___97813 acupuncture, one or more needles with electrical stimulation, initial 15 minutes of personal one-to-one contact with the patients

___97814 each additional 15 minutes, acupuncture, one or more needles without electrical stimulation, initial 15 minutes of personal one-to-one contact with the patients with re-insertion of needles

Treatment points: ____

Additional treatment points:____________________________________

Trigger point release:
___front:____

___back:____

Modalities:
___97026 infrared therapy on______________________

Progress: Patient shows ___ steady improvement ___ slow improvement ____Worsened ___unchanged

___continue treatment as prescribed ___ re-evaluate treatment program

Licensed acupuncturist Irina Kozina, L.Ac.