

Patient Information Sheet

Women's Health

Name: _____ Date _____

Home

Street _____

City, State, Zip _____

Home Phone _____ Cell Phone _____

Email _____ Birth date _____

Work

Address _____

City, State, Zip _____

Phone _____ Email _____

Emergency

Physician Name and Phone number _____

Person(s) to contact in case of an emergency _____

Address & Phone Number _____

Medications and Supplements

Please list any medications and supplements you are currently taking, including vitamins.

Areas of Main Concern

Please list your areas of main concern in order of priority (get detailed). Use the back of the page if necessary.

1. _____

2. _____

3. _____

How did you hear about Shams Wesley? _____

Health History

Mark an X in the box for any of the following that apply.

	You	Father	Mother	Siblings	Spouse
Allergies/Asthma					
Anemia					
Clotting problems					
Diabetes					
Cancer or tumor					
Epilepsy					
Glaucoma					
Genetic disease					
Alcoholism					
Nervous breakdown					
Rheumatism or arthritis					
High blood pressure					
Heart trouble					

Circle any of the following that you now have or have ever had.

- | | | | |
|-----------------------|--------------------|----------------------|-------------------|
| Eye Disease/Infection | Pneumonia | Neuralgia/Neuritis | Scarlet fever |
| Thyroid disease | Pancreatitis | Tension/anxiety | Measles |
| Eczema | Liver disease | Depression | Mumps |
| Hernia | Hyperactivity | Polio | Yellow jaundice |
| Hemorrhoids | Chicken pox | Rheumatic fever | Tuberculosis |
| Drug abuse | German measles | Malaria | Hepatitis (any) |
| Lyme disease | Osteoporosis/penia | Anorexia/Bulimia | Blood transfusion |
| Mononucleosis | Ulcerative Colitis | Hives or rashes | Bronchitis |
| Hepatitis | Chrones Disease | Diverticulitis/losis | Psoriasis |
| Obesity | Candida Overgrowth | Parasites | Leaky Gut |

Hospitalizations

	Year	Operation or Illness
1 st Hospitalization		
2 nd Hospitalization		
3 rd Hospitalization		
4 th Hospitalization		

Check the appropriate box for any of the following that you now have or have ever had.

	Current problem	Past problem	Never a problem		Current problem	Past problem	Never a problem
Yeast Infections				Breast lumps			
Tubal ligation				Fibroid tumors			
Pelvic Inflammatory Disease (PID)				Abnormal vaginal or anal PAP smear			
Abnormal mammogram				Abnormal vaginal bleeding			
Menopause				Trichomonas			
Infertility				Syphilis			
Hair loss				HIV / AIDS			
Trichomonas				Herpes			
Syphilis				Chlamydia			
HIV / AIDS				Vaginal discharge			

Please list the details of any ART (artificial reproductive therapy). Use back of sheet if needed.

	How many?	Dates	Name and dose of meds taken	Result	What was recommended next?
IUI (insemination)					
IVF (in vitro fertilization)					
Medication only					

Cause of infertility (if that is why you are seeking treatment) (circle answers)

Amenorrhea	Not ovulating	PCOS	Endometriosis
Poor egg quality	Over or underweight	Genetic factors	Smoking
Luteal phase too long or short	Blocked fallopian tubes	Past Chemotherapy/ Radiation	Anti-sperm antibodies
Low estrogen or progesterone	Luteal phase too long or short	Uterine problem not listed	Excessive alcohol consumption

Health History

If a symptom is from pregnancy or trying to become pregnant, write "P" in the box next to it.

If a symptom is long-term or not pregnancy-related, put a CHECK in the box next to it.

Often feel tired
At times have a weak appetite for food
At times have loose and/or watery stools
At times have undigested food in your stools
Often belch after eating or drinking
At times have difficulty swallowing
At times have intestine/stomach pain or gurgling
At times feel bloated after eating or drinking
At times feel nauseous
At times have mucousy or sticky stools
At times have heavy limbs or head
Gained/lost more than 10 lbs in last 6 months
Traveled outside the US in the last 6 months
Have lumps or swellings anywhere
At times have stuffy nose/sinuses when not sick
At times have food sit in your stomach like a rock
Experience frequent hunger
At times feel unsatisfied after you eat
At times have heartburn or reflux
Prefer cold liquids
At times have swelling, bleeding, or painful gums
Prefer warm foods and liquids
Have any skin problems
Tend to have dry skin
Tend to have oily skin
At times have itchy or burning skin
At times have nosebleeds when the heat is on
At times have hoarse voice or voice loss
At times feel sensitive to contact irritants
Ever experience irregular breathing
At times feel short of breath
Tend to catch whatever is going around
Feel susceptible to drafts
Have coughing bouts or wheezing
Tend to run cold

At times have swelling in your legs, ankles or feet
Generally have clear-colored urine
Ever have diarrhea in the a.m., soon after waking
Have a weak, tired or achy back or knees
Experience low libido
Tend to run hot
Ever have difficulty sitting still/feel restless
At times feel dry and dehydrated
At times have very yellow urine
Ever sweat at night
Ever feel hot in the afternoon
Have a brittle or tight back or knees
Notice your hearing has been getting worse
Ever hear a low or dull ringing in your ears
Have a fertility problem
Have partially/fully white hair
Have partial or full balding
Have a history of ever having significant hair loss
Urinate more than 6-7 times a day
Experience incontinence, bedwetting, dribbling
Suffer from frequent and/or urgent urination
Ever find it difficult to start the flow of urine
Ever have a weak or slow urine stream
Ever experience pain or burning with urination
Ever have blood in your urine
Ever have cloudy urine
Ever have Kidney or Gall Bladder stones
Drink at least four 8 oz glasses of water a day
Drink more than 16 oz. of coffee, tea or soda daily
Notice any body part always feels numb/odd
If yes, where
Ever get dizzy upon standing
At times have muscle cramps or spasms

Health History

If a symptom is from pregnancy or trying to become pregnant, write "P" in the box next to it.

If a symptom is long-term or not pregnancy-related, put a CHECK in the box next to it.

Ever have blurry vision
Ever seen floaters
At times have dry eyes
Have dry, weak, ridged or brittle fingernails
Ever have tightness, pressure in ribs or chest
Ever have a feeling of a lump in your throat
At times have a tight neck and/or shoulders
At times get tension headaches
At times feel troubled by gas
At times feel constipated
Have you been diagnosed with hypertension
Have you ever had high cholesterol
Have a fiery temper
Imbibe one or more alcoholic drinks a day
Ever used illegal drugs
Regularly use sleeping pills, pain killers, etc.
Ever have a sudden or urgent need to pass a b.m.
Notice your stools at times have a very bad odor
Ever feel a burning or itching around your anus
At times have twitching muscles, tics or tremors
Have you ever fainted or lost consciousness
Have you ever had convulsions or a seizure
Ever notice your own heartbeat
Wake up several times during the night
Often feel anxious, nervous or uneasy
Often forget things (like where your car keys are)
Startle easily, feel jumpy or unsettled
Ever get tongue/mouth canker sores, ulcerations
Ever toss and turn all night, feeling hot/agitated
Have Attention Deficit Disorder or ADHD
Have trouble focusing or get distracted easily
Tend to be shy or sensitive
Feel lonely or sad

Feel as if you're carrying a large burden
Feel clingy or needy
Tend to feel isolated
Carry a lot of grief or regret
Have difficulty relaxing
Spend most of your time working
Feel troubled by frightening dreams or thoughts
Often feel overwhelmed
Have a hopeless outlook
Find it hard to make decisions
Have a fixed or stabbing pain anywhere
Have scar tissue from injuries or surgeries
Have a history of masses or tumors
Have times in your life you cannot remember
Have pain or soreness in muscles, tendons, joints
Does this pain fluctuate with weather changes
Is the pain fixed
Is there local swelling

Informed Consent

I, the undersigned, hereby request that Shams Deckter Wesley, L.Ac., M.Ac., and/or other licensed acupuncturists who now or in the future treat me while employed by, working/associated with, or serving as back-up for Shams Deckter Wesley, including those working at the clinic or office referred to 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, Tiu-Na (Chinese massage), Shiatsu (acupressure), 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, dizziness or fainting, and potentially an aggravation of symptoms existing prior to the acupuncture treatment. Clients with severe bleeding disorders or pace-makers should inform the acupuncturist prior to treatment. Bruising is a common side effect of cupping. Unusual risks of acupuncture include: nerve damage and organ puncture, including lung puncture (pneumothorax), and spontaneous miscarriage. Infection is another possible risk, although the clinic uses sterile, disposable needles one time only and maintains a clean and safe environment.

Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes 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 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.

_____ **Initial:** I have read or had read to me the above consent and by signing below I agree to the above named procedures, and intend this consent to cover my entire course of treatment for the present or future conditions for which I seek treatment.

_____ **Initial:** I understand that an acupuncturist licensed in the state of Georgia will perform this treatment. The acupuncturist is trained in the field of Oriental Healing Arts and is not making a medical diagnosis of a disease or medical condition. I understand that a medical condition can only be diagnosed and advised upon by a licensed physician.

_____ **Initial:** I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the known facts, is in my best interest.

_____ **Initial:** All my records will be kept confidential and will not be released without my written consent, but they may be reviewed by the clinical and administrative staff at this office.

_____ **Initial:** I hereby release Shams Deckter Wesley, M.Ac., L.Ac. and any practitioner I receive treatment from in this office from all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care.

_____ **Initial:** Your appointment is a time set aside for you and the acupuncturist. In order to ensure each patient's time is respected, **a \$25 charge may be applied to missed appointments or cancellations with less than 12 hours notice.** We appreciate your consideration and your understanding that others may be waiting for the appointment you miss.

Patient's Name (printed): _____ **Date** _____

Patient's Signature: _____

Signature of Legal Guardian (if patient is underage): _____

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, 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 _____. This agreement is effective as of 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's Name (printed): _____

Patient's Signature: _____

Signature of Legal Guardian (if patient is underage): _____