NEW PATIENT PAPERWORK

Dear Patient,

Welcome and thank you for choosing us as part of your wellness team!

How this works:

Step1:

Please complete the following questionnaire to the best of your ability and return to our office via email or mail. During your initial consultation, we will review your health history together and clarify your wellness goals. If necessary, I will make recommendations for lab tests that are appropriate for your specific heath concerns.

Step 2:

Once you have completed your lab tests and the results processed, we will discuss these results in a follow up consultation. We will create an individualized program for you including dietary changes, nutritional supplements, detoxification programs, acupuncture, exercise, and lifestyle and stress management advice.

Step 3:

Subsequent consultations are scheduled to monitor your progress.

We invite you to contact us via email or phone should you have any questions or concerns during the course of your treatment.

We look forward to assisting you in achieving you current wellness goal and creating a fulfilling, healthy, vibrant future.

Sincerely,

Nathalie Trees, L.Ac., DMQ, CBT
Trees Acupuncture and Functional Medicine
200 Camino Aguajito, Suite 303
Monterey, Ca 939340
831-917-0365

POLICIES AND PROCEDURES

Patient copy

New patients:

First Appointment

Your first consultation will be 45 minutes to one hour. During this time we will determine the appropriate lab tests you should order to address your specific health concerns.

1. Payment is due at time of consultation with cash, check, or Visa/MasterCard.
2. All consultations are timed from the time the appointment begins; you will only be billed for the actual time used.
3. We do not provide insurance billing. As a courtesy to you, we will provide you with a super-bill to send to your insurance company upon request. Any reimbursements from your insurance company will be sent to you directly.

Appointments:

- Follow-ups consultations may be scheduled in 30 or 60-minute blocks of time.
- We encourage you to book your appointments 2 weeks in advance.
- As a courtesy to you, you will receive a reminder for your appointment via email.

Lab tests:

- The results of your lab test(s) will be sent to us 2 to 4 weeks after mailing your specimens to the lab.
- We will evaluate the results. After evaluation you will be contacted to schedule a follow-up appointment.

Cancellations:

- If you are unable to keep your scheduled appointment, you must notify our office a minimum of 24 hours before your scheduled time or you may be charged for that appointment.

Returned Products:

- Pre approval is required on all returns.
- No supplement returns will be accepted after 30 days an all regularly stocked items. Special orders cannot be returned.
- Prepaid tests can be returned for credit within one year of purchase.

Important Notes:

- We do not service medical emergencies. If you have a medical emergency, you must contact your primary care physician or dial 911.
- Please contact the office if you are not clear on any of our policies or procedures.

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I _____ have read and understood that Policies and Procedures. (Please print name)

Date_____ Signature _____

ARBITRATION AGREEMENT

Patient name: _____

Article 1: Agreement to arbitrate: It is understood that any dispute as to medical malpractice, that is 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 state and federal law provides for judicial review or 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 ajury, 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 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 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, economical 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 fee 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 the California Medical Injury Compensation Reform Act 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 payment (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to the 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 is 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: The 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 dates it is signed (for example emergency treatment) patient should initial here ____ . Effective as the date of first professional services.

If any provision of tis 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 _____ date _____
(or patient Representative) (indicate relationship if signing for patient)

OFFICE SIGNATURE _____ date _____

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 of 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, Tiu-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 u=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. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung perforation (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 a potential risk of moxibustion and cupping. 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 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 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 intent 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 _____
(or patient representative) (indicate relationship if signing for patient)

I clearly understand that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand the if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize you to release my personal medical records to me.

Patient's Signature: _____ Date: _____

Name:		Date:
Address:		City:
State:	Home Phone:	Cell Phone:
Email:		
Age:	Birthdate:	Sex: M ☐ F ☐ Status: S ☐ M ☐ D ☐ W ☐
Occupation:		Years:
How will you pay?	Insurance Co Name:	Group #:
What are your top 4 healthcomplaints?		
What are your overall health goals once your complaints are resolved?		
How long has it been since you really felt good?		

Please answer all questions frankly, to the best of your knowledge. All information is confidential.

Weight _____ Height _____ Blood pressure (if known) _____ % Body Fat (if known) _____

1. Are you presently taking any medications, nutritional supplements, or vitamins? _____
   Please list (attach sheet if necessary).

   _____

   _____

2. In the past, have you used birth control pills and/or antibiotics? _____
   For how long? _____

3. If you have fillings, please list material(s) used: _____
4. Do you presently, or have you ever had any of these conditions? (circle)

Anemia ☐	Arthritis ☐	Asthma ☐
Chest pains ☐	Chronic cold/flu symptoms ☐	Chronic fatigue ☐
Depression ☐	Diabetes ☐	Frequent Headaches ☐
Heartburn ☐	High blood pressure ☐	High cholesterol ☐
Hypoglycemia ☐	Kidney problems ☐	Liver problems ☐
Osteoporosis ☐	Skin condition ☐	Thyroid condition ☐
Unexplained weight change ☐		

5. How much sleep do you get each night on average? _____

6. Do you have any food allergies, sensitivities or restrictions? _____

   _____

   _____

7. Do you smoke, drink alcohol, or use recreational drugs? _____

   How much, how often? _____

   How often do you drink caffeinated beverages? _____

8. Please list foods you tend to overeat or crave (sweets, breads, fatty foods, meats, milk, etc…)

   _____

   _____

9. Are there foods that you eat on a daily basis, almost daily basis? _____

_____

Do you "miss" these foods if you do not eat them? _____

10. Write briefly about your weight gain/loss history: _____

_____

_____

What do you feel triggered your weight fluctuation? heredity ☐ stress ☐ eating habits ☐ boredom ☐

Was your weight gain/loss: (circle) sudden ☐ gradual ☐ problem since childhood ☐

11. Please list close relatives that have diabetes, heart disease, or obesity: _____

_____

12. What methods have you tried to lose/gain weight? _____

_____

13. How is your energy level? _____

Are there times in the day when you feel best? _____ Worst? _____

14. Are you happy in your life right now? _____

15. What are your main sources of stress? _____

_____

16. How do you deal with your stress? _____

_____

17. Please answer the next questions Yes or No:

If I'm feeling down, a snack makes me feel better. Yes ☐ No ☐

I sometimes have a hard time going to sleep without a bedtime snack. Yes ☐ No ☐

I get tires and/or hungry in the mid-afternoon. Yes ☐ No ☐

I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta, or dessert. Yes ☐ No ☐

Now and then I think I am a secret eater. Yes ☐ No ☐

At a restaurant, I always eat too much bread before the meal is served. Yes ☐ No ☐

I have difficulty concentrating, or frequent fussy or spacey thinking patterns. Yes ☐ No ☐

I experience cravings for sugar, breads, pasta, and baked goods. Yes ☐ No ☐

I feel shaky if I don't eat on time or if I don't snack. Yes ☐ No ☐

I often find myself irritable or angry. Yes ☐ No ☐

18. Check off any of the following that have applied to you <u>within the past 30 days</u>:

☐ Do you feel nauseous?

☐ Do you have bloating?

☐ Do you get heartburn?

☐ Do you have constipation?

☐ Do you have gas?

☐ Do you belch following meals?

☐ Do you bowel movements alternate between constipation and diarrhea?

☐ Do you have abdominal/intestinal pain?

Do you get bloated after meals?

☐ Do you have diarrhea?

Do you travel outside of the U.S.?

☐ Are your stools compact/hard to pass?

☐ Do you have gurgles in your stomach?

19. In your estimation, how physically fit are you right now?

Unfit ☐ Below average ☐ Average ☐ Above average ☐ Very fit ☐

20. How often do you exercise? _____

What is your regimen? _____

_____

21. If you do not currently exercise, what types of exercises have you enjoyed doing in the past?

_____

22. What are your fitness goals? (check all that apply)

- ☐ general fitness endurance
- ☐ Weight loss/maintain weight
- ☐ Osteoporosis prevention
- ☐ Specific sport enhancement
- ☐ flexibility
- ☐ Muscle toning
- ☐ Muscle strengthening
- ☐ Muscular coordination/balance

Other _____

23. Surgeries, starting with most recent: _____

24. Hospitalizations: _____

25. Briefly describe where you have lived since childhood: _____

_____

_____

26. What is your heritage? (Irish, German, Spanish, etc…) _____

27. Circle "Now" or "Past" for only those items with which you identify. Ignore anything that does not apply to you.

Is your life:	**Do you often:**
☐Now ☐Past Satisfactory	☐Now ☐Past Feel depressed
☐Now ☐Past Boring	☐Now ☐Past Have anxiety
☐Now ☐Past Demanding	Do you often:
☐Now ☐Past Unsatisfactory	☐Now ☐Past Have irrational fears
Do you worry over:	☐Now ☐Past Feel upset
☐Now ☐Past Home life	☐Now ☐Past Feel things go wrong
☐Now ☐Past Marriage	☐Now ☐Past Feel shy
☐Now ☐Past Children	☐Now ☐Past Cry
☐Now ☐Past Job	☐Now ☐Past Feel inferior
☐Now ☐Past Income	**Have you:**
☐Now ☐Past Money problems	☐Now ☐Past Seriously considered suicide
	☐Now ☐Past Attempted suicide

BLOOD SUGAR INSTABILITY QUESTIONNAIRE

Do any of the following apply to you?

Yes	No	
☐	☐	Family history of diabetes, hypoglycemia or alcoholism
☐	☐	Calmer after meals
☐	☐	Frequent thirst
☐	☐	Night sweats (not menopausal)
☐	☐	Crave salt foods
☐	☐	Dark circles under eyes or eyes sensitive to bright lights
☐	☐	More awake at night
☐	☐	Food cravings
☐	☐	Headaches
☐	☐	Irritability
☐	☐	Mood swings
☐	☐	Easily fatigued
☐	☐	Anxiety
☐	☐	Difficulty sleeping
☐	☐	Mental sluggishness
☐	☐	Eat when nervous
☐	☐	Excessive appetite for carbohydrates or sweets
☐	☐	Hungry between meals
☐	☐	"Shaky" if hungry
☐	☐	Lightheaded if skip meals
☐	☐	Low energy in afternoon
☐	☐	Afternoon headaches
☐	☐	Crave sweets or coffee in afternoon

1. What is your relationship with food?

_____

_____

_____

2. What is your first memory of food?

_____

_____

_____

3. Are you a compulsive over-eater?

_____

_____

_____

4. What was your first problem with food?

5. Do you have a history of eating disorders? Is there alcoholism in your family?

6. What is your family's relationship with food?

7. Do you use alcohol or drugs to control your weight?

8. How often are you eating? Is there anything you eat too little or too much of?

9. Are you or is anyone concerned about your eating or your weight?

Adrenal Fatigue Checklist

Rate the following from 0 to 5, with 0 being no problem and 5 being a severe problem.

	Difficulty getting up in the morning		Increased PMS
	Fatigue that is not relieved by sleep		Symptoms worsen if meals are skipped or inadequate
	Lack of energy to do your daily activities		Difficulty with mental focus, brain fog
	Sugar cravings		Poor memory
	Salt cravings		Decreased tolerance for stress, noise, disorder
	Allergies		Don't really wake up until after 10 am.
	Digestion problems		Afternoon low between 3 and 4 pm
	Increased effort needed for everyday tasks		Feel better after a meal
	Decreased interest in sex		Get a “second wind” late in the evening and stay up late
	Decreased ability to handle stress		Procrastination and difficulty getting things done.
	Difficulty recovering from injuries, illnesses, or traumas		Have to keep moving- if I stop, I get tired.
	Light headed or dizzy when standing up too quickly.		Feeling overwhelmed by everything that needs to get done.
	Low mood		Very little energy left over for people I care about
	Less enjoyment and happiness with life.		
			Total:

20-40 Mild Adrenal Stress
40-70 Suggests Moderate Adrenal Stress
>70 Significant Adrenal Problems

ADVERSE CHILDHOOD EXPERIENCE (ACE) QUESTIONNAIRE
Finding your ACE score

While you were growing up, during your first 18 years of life:

1. Did a parent or adult in the household **often**…
   Swear at you, insult you, put you down, or humiliate you?
   Or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes, enter 1 _____

2. Did a parent or another adult in the household **often**…
   Push, grab, slap, or throw something at you?
   Or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes, enter 1 _____

3. Did an adult or person a least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   Or
   Try or actually have oral, anal, or vaginal sex with you?
   Yes No If yes, enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   Or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes, enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   Or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes, enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes, enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   Or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   Or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes, enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes, enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes, enter 1 _____
10. did a household member go to prison?
    Yes No If yes, enter 1 _____

Now add up your "Yes" answers: _____ this is your ACE score.