Welcome to Dragon Rises College Student Clinic

Dear Patient,

We are honored that you've chosen us to support your health and wellness journey. At our clinic, you'll receive care rooted in Acupuncture and Chinese Medicine, including therapies such as acupuncture, moxibustion, herbal medicine, manual therapy, and dietary guidance.

Our mission is to help you achieve lasting health by addressing the root causes of imbalance through holistic, individualized care.

As a teaching facility, some appointments may be observed by students. Your participation is essential to their learning, and we sincerely appreciate your support in training the next generation of practitioners.

How Acupuncture & Chinese Medicine Can Support You

✓ Prevent illness and disease

✓ Activate the body's natural healing systems

✓ Relieve pain and discomfort

✓ Support emotional and mental balance

✓ Enhance vitality and overall well-being

Tips for Getting the Most from Treatment

• **Attend regularly** – Each session builds on the last for best results

• **Follow recommendations** – Lifestyle and diet guidance accelerates healing

• **Be patient** – Progress may be gradual but meaningful

• **Stay positive** – Your outlook influences your body's ability to heal

We look forward to supporting your health goals. If you find benefit in your care, we invite you to share your experience with others who may also benefit from Acupuncture and Chinese Medicine.

Sincerely,

Dragon Rises College of Oriental Medicine

6815 14th St. W.
Bradenton, FL 3420

(941)289-0450
Follow Us on Social Media:

info@dragonrises.edu
Dragonrises.edu

Privacy Practices Policy

Procedures:

Uses and Disclosures of Health Information

Treatment:

We may use or disclose your health information to physicians or healthcare professionals involved in your care. This may include, but is not limited to, your primary care physician, physician assistant, nurse, physical therapist, nutritionist, or dentist.

Healthcare Operations:

We may use or disclose your health information for healthcare operations, such as quality assessment, reviewing the qualifications of healthcare professionals, performance evaluations, training, accreditation, certification, licensing, and credentialing.

Patient Authorization:

In addition to treatment, payment, or operations, we may release your health information to others only with your written authorization. You may revoke this authorization in writing at any time. Revocation does not affect any disclosures made while the authorization was in effect.

Family and Others Involved in Your Care:

With your permission, we may disclose health information to family members or others involved in your care or payment for care. We may also use professional judgment to allow a person to pick up prescriptions or health-related items if it appears to be in your best interest.

Required by Law:

We may use or disclose health information when required by law.

Public Health Activities:

We may disclose health information to public authorities for purposes such as reporting vital statistics, communicable diseases, or product recalls.

Health Oversight:

We may disclose health information for audits, investigations, or determining eligibility for government programs.

Law Enforcement:

Subject to certain conditions, we may disclose health information to law enforcement officials as required by law.

Serious Threat to Health and Safety:

We may use or disclose health information when necessary to prevent a serious threat to your health or safety, or to that of others.

Workers' Compensation:

We may disclose health information as required for workers' compensation or similar programs.

Abuse or Neglect:

We may disclose information to authorities if we believe you may be a victim of abuse, neglect, domestic violence, or other crimes, or to prevent a serious threat to your safety or others'.

Appointment Reminders and Treatment Information:

We may contact you regarding appointment reminders, changes, treatment alternatives, or to return your calls. We will request written instructions on your preferred method of telephone contact.

Patient Rights

Access:

You have the right to view or obtain copies of your health information. Requests must be made in writing. We may charge a $25 fee or a reasonable cost-based fee for copies and staff time.

Disclosure Accounting:

You have the right to receive a list of non-treatment-related disclosures of your health information. If requested more than once in a 12-month period, we may charge a reasonable fee for additional requests.

Restrictions:

You may request restrictions on how we use or disclose your information. While we are not required to agree, if we do, we will follow the agreed restrictions, except in emergencies.

Amendments:

You may request that we amend your health information. Requests must be in writing and include the reason for the change. We may deny requests under certain conditions.

Revocation of Consent:

You may revoke your consent in writing at any time. This will not affect any use or disclosure made before the revocation. We reserve the right to decline or discontinue treatment if consent is revoked.

Complaints

You have the right to file a complaint if you believe your privacy rights have been violated or if you disagree with a decision regarding your health information.

Contact:

Privacy Officer: Academic Dean
Phone: 941-289-0450 ext. 107

You may also file a complaint with:

U.S. Department of Health and Human Services
Attention: Office of Civil Rights
Sam Nunn Atlanta Federal Center, Suite 3870
61 Forsyth Street SW
Atlanta, GA 30303-8909

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that I am under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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 indicated 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 have 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 appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). 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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

PATIENT NAME:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE: **X**

(Or Patient Representative)

(Indicate relationship if signing for patient)

IN ADDITION, PLEASE SIGN THE ARBITRATION AGREEMENT PROVIDED

Client Consent Form

For Use & Disclosure of Health Information

Consent for Use and Disclosure of Health Information

By signing below, I consent to the use and disclosure of my protected health information for treatment, payment, and healthcare operations. I understand that I may review the Notice of Privacy Practices before signing. This notice may change, and I may request an updated copy at any time.

I Understand That:

- ◯ I may revoke this consent in writing at any time.
- ◯ Revoking consent does not affect actions already taken.
- ◯ Revocation may result in discontinuation of care.

I authorize disclosure of my health information to:

- ◯ No one at this time
- ◯ Spouse: _____ Phone: _____
- ◯ Family Member: _____ Phone: _____
- ◯ Other: _____ Phone: _____

By signing below I agree that I have read and understood this consent.

Signature: _____ Date: _____

Revocation of Consent

I revoke my consent for the use and disclosure of my protected health information. I understand this does not affect any prior actions and may result in discontinuation of care.

Signature: _____ Date: _____

NO-SHOW, LATE ARRIVAL & CANCELLATION POLICY

Definitions:

- **No-Show:** Missing an appointment without notice.
- **Same-Day Cancellation:** Canceling less than 24 hours before the appointment.
- **Late Arrival:** Arriving 15 or more minutes late.

Policy Overview:

To ensure all patients receive timely care, we require at least 24 hours' notice for appointment changes.
Failure to do so limits access for other patients and may result in a fee or dismissal from the clinic.

Procedures:

General Guidelines (All Patients):

- Appointments must be canceled at least 24 hours in advance.
- Late arrivals may be rescheduled and subject to a $45 missed appointment fee.
- Three (3) documented no-shows or late cancellations may result in dismissal from the clinic, at the discretion of the Clinic Director.

Established Patients:

- Less than 24-hour notice may result in a $45 fee.
- Late arrivals that cannot be accommodated will be rescheduled and may be charged at the provider's discretion.
- Dismissal is considered after 3 policy violations.

New Patients:

- Must provide 24-hour cancellation notice or be subject to the $45 fee.
- No-shows may result in rescheduling or a charge.
- Repeated same-day cancellations (3 times) may result in dismissal.

Reminders & Courtesy Notices:

- Text reminders are sent 1–2 days in advance.
- Not receiving a reminder does not exempt you from this policy.
- You may cancel via phone, voicemail, or by replying to your appointment reminder text.

Patient Acknowledgment

I have read and understand the No-Show, Late Arrival, and Cancellation Policy. I acknowledge that I may be charged a **$45 fee** for missed appointments or late cancellations and understand that repeated violations may lead to dismissal from the clinic. I understand the terms may be updated as needed.

Printed Name:_____

Signature: _____

Date: _____

(941) 289 - 0450

DragonRises.edu
hinfo@dragonrises.edu

6815 14th St. W.
Bradenton, FL 34207

Dragon Rises College of Oriental Medicine

Patient Information Form:

Please complete this form in either blue or **black** ink ONLY.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____Work Phone:_____

Cell Phone: _____ Email Address:_____

Occupation: _____Business Address: _____

City: _____ State: _____ Zip: _____Place of Birth: _____

Date of Birth: _____ Age: _____ Height:_____ Weight: _____ Sex (at birth): M / F

Relationship Status: (Single, Married, Divorced, Widowed, Other:_____)

Contact In Case of Emergency:

Name: _____ Cell Phone: _____

How did you hear about our clinic?_____

When and where did you last receive health care? _____

Have you utilized acupuncture and Chinese medicine previously to coming to our clinic? Yes No

- Do you have any reason to believe you may be pregnant? Yes No
  - If so, how far along are you? _____
- Do you have any infectious diseases? Yes No
  - If yes, please identify the condition:_____

Has your medical case been referred to an attorney? Yes No

Please list your primary health complaints/concerns._____

_____

_____

Please rate the extent to which your current complaints affect your daily life (1=minor, 10=major):

(Minor) 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ (Major)

Please rate your commitment to resolving your problems (1=minor, 10=major):

(Minor) 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ (Major)

Please list any medications (including natural remedies) you are currently taking or attach a list:

_____

_____

_____

Please list any known allergies or sensitivities to food, herbs, or medications:

_____

_____

_____

List any and all previous "significant health events" in chronological order (include surgeries, traumas, illnesses):

Health Event *Ex. Concussion from bicycle accident*	**Age Occurred** *5 Years old*
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	

General Health Assessment: Please check all symptoms that apply.

Be sure to include any symptoms or conditions you currently experience, even if they are managed with medication.
Example: If you take medication for hypertension, and your condition is currently controlled, please still include it as one of your complaints.

Family's Medical History Only:

(Please indicate just your family history of diseases ↓, not your current history)

- ☐ Alcoholism
- ☐ Asthma
- ☐ Allergies/Hay Fever
- ☐ Cancer
- ☐ Degenerative Conditions (e.g., MS)
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Infectious Disease
- ☐ Kidney Disease
- ☐ Lyme Disease
- ☐ Mental Illness: _____
- ☐ Rheumatic Fever
- ☐ Parkinson's Disease
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Other Family Illnesses:_____

_____

_____

Please fill out the next section as thoroughly as possible. Speak to other family members. This information may come as family anecdotes.

Personal Birth-Childhood History:

- ☐ Alcohol/drug use by mother prior to or during pregnancy
- ☐ Alcohol/drug use by father prior to pregnancy
- ☐ Mother and/or father exposed to toxins before conception or during pregnancy
- ☐ Venereal disease in mother or father prior to pregnancy
- ☐ Emotional/physical trauma experienced by mother during pregnancy
- ☐ Illness of mother during pregnancy (please list):_____
- ☐ Poor nutrition by mother prior to or during pregnancy
- ☐ Medication used by mother during pregnancy (please list):_____
- ☐ Mother smoked or was exposed to secondhand smoke
- ☐ Prior miscarriage by mother before this pregnancy (please list details):_____
- ☐ Late delivery
- ☐ Premature delivery
- ☐ Rapid labor by mother
- ☐ Prolonged or slow labor by mother
- ☐ Labor was induced
- ☐ Epidural used during labor
- ☐ High forceps delivery
- ☐ Breech birth
- ☐ Cord wrapped around neck
- ☐ Cesarean section
- ☐ Placenta previa
- ☐ Birth weight (in lbs):_____
- ☐ Spent time in incubator after birth
- ☐ Jaundiced as an infant
- ☐ Mother hospitalized after childbirth beyond usual post-delivery period
- ☐ Bottle-fed
- ☐ Breastfed by mother
- ☐ Colic
- ☐ APGAR score: _____
- ☐ Number of siblings:_____
- ☐ Position among your siblings:_____
- ☐ Health during childhood:
  ◯ Good ◯ Fair ◯ Poor
- ☐ Slow or delayed development
- ☐ Childhood obesity
- ☐ ADD/ADHD
- ☐ Hyperactivity
- ☐ Learning disabilities (please specify):

  _____
- ☐ Physical, emotional, or sexual abuse
- ☐ Sleep patterns during childhood (please describe): _____
- ☐ Illnesses or hospitalizations during childhood: _____
- ☐ Vaccine reactions (please describe):

  _____

Ears, Eyes, & Mouth Health:

- ☐ Ear discharge
- ☐ Ear pain
- ☐ History of ear infections (please describe):

_____

- ☐ Hearing loss
- ☐ Ringing in the ears (tinnitus)
- ☐ Cataracts
- ☐ Conjunctivitis
- ☐ Dry, itchy, or watery eyes
- ☐ Double vision
- ☐ Eye strain or fatigue
- ☐ Floaters (spots in visual field)
  Color/shape:_____
- ☐ Glaucoma
- ☐ Glasses/contacts (please specify):

_____

- ☐ Gritty or sticky sensation in the eyes
- ☐ Macular degeneration
- ☐ Styes
- ☐ Bleeding gums
- ☐ Blisters or canker sores
- ☐ Gingivitis or gum disease
- ☐ Other:_____

Hair, Nail, & Skin Health:

- ☐ Brittle or dry hair
- ☐ Dandruff
- ☐ Hair loss (alopecia)
- ☐ Nail fungus (hands or feet)
- ☐ Poor nail health or irregularities
- ☐ Acne
- ☐ Boils
- ☐ Body odor
- ☐ Skin cancers (melanoma, basal cell, etc.)
- ☐ Cold sores (herpes simplex)
- ☐ Dry skin
- ☐ Excessive perspiration
- ☐ Hives or rashes
- ☐ Itchy skin
- ☐ Lipomas (fatty tissue growths)
- ☐ Moles (new or changing)
- ☐ Oily skin
- ☐ Reactions to insect bites
- ☐ Scars (locations):_____
- ☐ Sebaceous cysts
- ☐ Shingles (herpes zoster)
- ☐ Skin tags
- ☐ Swellings, lumps, or nodules
- ☐ Warts
- ☐ Other:_____

Respiratory Health:

- ☐ Allergies / Hay fever
- ☐ Asthma
- ☐ Bronchitis
- ☐ Frequent colds
- ☐ Cough (acute or chronic)
- ☐ Emphysema
- ☐ Hoarseness
- ☐ Laryngitis
- ☐ Nasal congestion
- ☐ Excessive phlegm production
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Post-nasal drip
- ☐ Shortness of breath
- ☐ Snoring
- ☐ Sore throat (acute or chronic)
- ☐ Other: _____

Blood / Cardiovascular Health:

- ☐ Anemia
- ☐ Aneurysm
- ☐ Angina / Heart pain
- ☐ Blood clots
  Blood type: ☐ A ☐ B ☐ AB ☐ O
  Rh factor: ☐ Positive ☐ Negative
- ☐ Bruise easily
- ☐ Chest pain or tightness
- ☐ Cold hands and feet
- ☐ History of heart attack
- ☐ Irregular heartbeat
- ☐ Heart disease
- ☐ High cholesterol
- ☐ Hypertension (high blood pressure)
- ☐ Hypotension (low blood pressure)
- ☐ Mitral valve prolapse
- ☐ Heart murmur
- ☐ Palpitations
- ☐ History of stroke
- ☐ Varicose veins
- ☐ Other: _____

Gastrointestinal Health:

- ☐ Abdominal pain or cramps
- ☐ Acid reflux / Heartburn
- ☐ Anorexia or Bulimia
- ☐ Bloating and distension
- ☐ Chronic use of laxatives
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Constipation
- ☐ Diarrhea
- ☐ Esophageal spasms
- ☐ Food allergies / sensitivities
- ☐ Gallbladder disease
- ☐ Gas / Flatulence
- ☐ Intolerance to greasy or fatty foods
- ☐ Liver disease (e.g., cirrhosis)
- ☐ Fatty liver
- ☐ Hemorrhoids
- ☐ Hiccups
- ☐ Indigestion
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Unusual taste in mouth (check all that apply):
  ◯ bitter ◯ metallic
  ◯ sticky ◯ sweet
- ☐ Nausea and/or vomiting
- ☐ Pancreatitis
- ☐ History of parasites
- ☐ Rectal itching
- ☐ Stomach or duodenal ulcers
- ☐ Stool characteristics (check any that apply):
  ◯ bloody ◯ tarry ◯ clay-colored
  ◯ mucus in stool ◯ undigested food

Frequency of bowel movements per day:_____

_____

Do your bowel movements float or sink? _____

_____

- ☐ Other:_____

Women's Reproductive History:

- ☐ Age of first menses: _____
- ☐ Length of menstrual flow: _____
- ☐ Time between cycles: _____
- ☐ Heavy bleeding
- ☐ Light bleeding
- ☐ Menstrual blood color: _____
- ☐ Clotting (describe color of clots): _____
  _____
- ☐ No menstruation (amenorrhea)
- ☐ Irregular menstruation
- ☐ Painful menstruation (dysmenorrhea)
- ☐ Premenstrual syndrome (PMS)
  (breast tenderness, irritability, cramps, etc.)
- ☐ Bloating or water retention with period
  # of abortions: _____
  # of live births: _____
  # of miscarriages: _____
- ☐ Traumatic births
- ☐ Use of birth control (include age & duration):_____
- ☐ Postpartum weakness
- ☐ Difficulty conceiving / Infertility

Women's Health (if applicable):

- ☐ Abdominal lumps or masses
- ☐ Breast cancer
- ☐ Breast cysts or lumps
- ☐ Breast tenderness
- ☐ Endometriosis
- ☐ Estrogen replacement use
- ☐ Fibroids
- ☐ Hot flashes
- ☐ Menopause (age begun): _____
- ☐ Menopausal symptoms
- ☐ Strong menstrual odor
- ☐ Nipple discharge
- ☐ Pelvic or genital pain
- ☐ Abnormal mammogram or Pap smear
- ☐ Severe menstrual cramps
- ☐ Pain during sex
- ☐ Low sex drive
- ☐ Excessive sex drive/Impulse control difficulty
- ☐ Vaginal discharge
- ☐ Vaginal dryness
- ☐ Vaginal odor
- ☐ Venereal disease
- ☐ Yeast infections
- ☐ Other: _____

Men's Health (if applicable):

- ☐ Erectile dysfunction
- ☐ Impotence
- ☐ Penile discharge
- ☐ Premature ejaculation
- ☐ Prostate enlargement / problems
- ☐ Seminal incontinence
- ☐ Low sex drive
- ☐ Excessive sex drive
- ☐ Venereal disease
- ☐ Other: _____

Endocrine Health:

- ☐ Addison's disease
- ☐ Cushing's syndrome
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Diabetes Insipidus
- ☐ Fatigue (time of day): _____
- ☐ Feeling hot or cold (circle one)
- ☐ Hypoglycemia
- ☐ Hypothyroidism
- ☐ Hyperthyroidism (Graves' disease)
- ☐ Insulin resistance
- ☐ Lethargy
- ☐ Pituitary disorders
- ☐ Night sweats
- ☐ Overweight

How many lbs. overweight?_____

- ☐ Sudden weight gain
- ☐ Weight loss
- ☐ Other: _____

Neurological & Brain Health:

- ☐ History of concussion
- ☐ Difficulty concentrating
- ☐ Drowsiness
- ☐ Epilepsy
- ☐ Lack of coordination or balance
- ☐ Loss of muscle strength
- ☐ Numbness or tingling in the limbs
- ☐ Paralysis
- ☐ Seizures
- ☐ Tremors
- ☐ Vertigo or dizziness

Musculoskeletal Health & Pain:

- ☐ Arm and elbow pain
- ☐ Hand and wrist pain
- ☐ Knee pain
- ☐ Leg and calf pain
- ☐ Gout
- ☐ Hip pain and/or sciatica
- ☐ Lower back pain
- ☐ Neck, shoulder, or upper back pain
- ☐ Whole body pain
- ☐ Facial pain or paralysis
- ☐ Jaw tension or pain (TMJ syndrome)
- ☐ Headaches (location & sensation):_____
  _____
- ☐ Migraines
- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Osteopenia (bone weakening)
- ☐ Osteoporosis (bone loss)
- ☐ Sciatica — (Check all that apply)
  ◯ back of leg ◯ side of leg ◯ both
- ☐ Spinal curvature (e.g., scoliosis, lordosis, kyphosis):_____
- ☐ Stress-related tension in the back, shoulders, or neck
- ☐ Other: _____

Immune Health & Toxicity:

- ☐ Candidiasis / Fungal infection
- ☐ Chemical sensitivities
- ☐ History of chemotherapy or radiation treatment
- ☐ Chronic Fatigue Syndrome
- ☐ Chronic infections (please specify):_____
  _____
- ☐ Epstein-Barr Virus
- ☐ Hepatitis (check all that apply):
  ◯ A ◯ B ◯ C ◯ D ◯ E
- ☐ HIV / AIDS
- ☐ Leukemia
- ☐ Lyme disease
- ☐ Lymph node swelling
- ☐ Lymphoma
- ☐ Mononucleosis
- ☐ Parasites (please specify): _____
- ☐ Reactions to food additives
- ☐ Recent or past exposure to toxins, chemicals, pesticides, herbicides, mold, etc. in the home or workplace
- ☐ Residence in a home older than 30 years

Environmental Adaptation:

- ☐ Changes in weather or barometric pressure aggravate symptoms or cause adverse reactions
- ☐ Cold / damp environments aggravate symptoms or cause adverse reactions
- ☐ Cold / dry environments aggravate symptoms or cause adverse reactions
- ☐ Hot / humid environments aggravate symptoms or cause adverse reactions
- ☐ Hot / dry environments aggravate symptoms or cause adverse reactions
- ☐ Seasonal changes aggravate symptoms or cause adverse reactions

Lifestyle (Please indicate amount or frequency):

☐ Alcohol consumption:_____
☐ Caffeinated or carbonated beverages:_____
☐ Coffee or black tea: _____
☐ Exercise: _____
☐ Recreational drug use (please list):_____
☐ Tobacco use:_____
☐ Water intake (daily): _____
How often do you eat?_____
Do you suffer from insomnia? ☐ Yes ☐ No
Is it more difficult to:
◯ Get to sleep ◯ Stay asleep ◯ Both
How many hours do you sleep per night?_____
If you sleep 8 hours, do you feel rested or still wake tired?
_____
_____

Psychological / Emotional Health:

- ☐ Anxiety
- ☐ Depression
- ☐ Excessive worry or over-concern
- ☐ Anger, frustration, or irritability
- ☐ Fear or paranoia
- ☐ Grief or sadness
- ☐ Bipolar disorder
- ☐ Schizophrenia
- ☐ ADD or ADHD
- ☐ Addictions (please list):

_____
_____
_____

- ☐ Attempted suicide
- ☐ Suicidal thoughts
- ☐ Panic attacks
- ☐ PTSD (Post-Traumatic Stress Disorder)
- ☐ Other: _____

Certification Statement:

I certify that the above information is true and correct to the best of my knowledge.

Patient Name: _____

Signature: _____

Date: _____

OFFICE USE ONLY

Student Name:_____ Supervisor Name:_____

Signature:_____ Signature: _____

Date: _____ Date:_____

Birth, Infancy, & Childhood History Details

Please provide as much detail as possible about any of the conditions checked above, as well as any other physical or emotional health issues from your birth or childhood. Many current health concerns have their roots in events that occurred during these formative years, and this information can be extremely valuable in guiding your assessment and treatment. Much of this information may come from family stories or recollections. Talk to family members to help fill in any gaps and gather as much insight as possible from this early stage of life.

Dragon Rises College of Oriental Medicine

Electronic Communications Agreement

BY SIGNING BELOW, I GIVE PERMISSION TO DRAGON RISES COLLEGE OF ORIENTAL MEDICINE AND ITS REPRESENTATIVES TO CONTACT ME BY PHONE, VIDEO CALL, EMAIL, AND/OR TEXT MESSAGE REGARDING:

- ◯ Appointments and scheduling
- ◯ Billing and payments
- ◯ Telemedicine treatments
- ◯ Test results and prescriptions
- ◯ Assessments and consultations
- ◯ Educational materials

I UNDERSTAND AND ACKNOWLEDGE THE FOLLOWING:

- ◯ Phone, email, video, and text communications are not guaranteed to be confidential or HIPAA-compliant.
- ◯ There is some risk of my private health information being seen by unintended parties.
- ◯ All relevant messages may be included in my permanent health record
- ◯ I should not send sensitive medical information via text or email.
- ◯ In an emergency, I will call 911 or contact my primary care provider.

BY SIGNING, I ALSO GIVE CONSENT TO RECEIVE TELEMEDICINE SERVICES.

I AUTHORIZE THE RECEIPT OF TELEMEDICINE SERVICES AND ELECTRONIC COMMUNICATIONS:

Patient Name: _____

Patient Signature: _____ Date: _____

Patient Representative (Relationship): _____

Representative Signature: _____

Phone Number: _____ Email Address: _____

OFFICE USE ONLY

Student Name: _____

Student Signature: _____

Supervisor Name: _____

Supervisor Signature: _____

Dragon Rises College of Oriental Medicine

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES POLICY

I, _____ , have received a copy of this office's Privacy Practices Policy.

I would like to receive telephone communication or messages via: (Check all that apply)

- ◯ Cell Phone: _____
- ◯ Home Phone: _____
- ◯ Work Phone: _____
- ◯ Other: _____

Please Print Name : _____

Please Sign Name : _____

Date: _____

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our notice of Policy Practices, but the acknowledgement could not be obtained because:

- ◯ Individual refused to sign
- ◯ Communication barriers prohibited obtaining the acknowledgment
- ◯ An emergency situation prevented us from obtaining acknowledgment
- ◯ Other: _____

Acupuncture Physician: _____

Date: _____

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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

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, as to whether this agreement is unconscionable, and any procedural disputes, 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 healthcare 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 healthcare provider and/or other licensed healthcare providers, preceptors, or 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 healthcare provider, including those working at the healthcare 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 healthcare provider, and/or the healthcare 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. This agreement is intended to create an open book account unless and until revoked.

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) and provide National Arbitration and Mediation ("NAM") with the party arbitrator's contact information within thirty days of the date Respondent files its initial responsive pleading. A third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties from a list of arbitrators supplied by National Arbitration and Mediation ("NAM") within thirty days thereafter. The list supplied by NAM shall be a list of between 5 and 10 arbitrators, depending upon availability. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal 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 damages 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, where not in conflict with this agreement, the Healthcare Malpractice Dispute Resolution Rules and Procedures of NAM shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of NAM rules are available on its website at https://www.namadr.com or by calling 1-800-358-2550 to request a copy of the rules.

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 healthcare 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 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: _____ Signature: _____ Date: _____

IN ADDITION, PLEASE SIGN THE ARBITRATION AGREEMENT PROVIDED

Dragon Rises College of Oriental Medicine

COVID-19 INFORMED CONSENT WAIVER

I understand that COVID-19 is a global pandemic, is highly contagious, and may be spread by individuals without symptoms. I acknowledge the following:

PLEASE INITIAL EACH STATEMENT:

_____ I understand receiving care may involve close contact and the potential spread of COVID-19.
_____ I understand this treatment is elective and may be postponed or provided by another type of provider.
_____ I understand that visiting a healthcare facility increases the risk of exposure to COVID-19.
_____ I confirm I am not currently experiencing symptoms such as fever, dry cough, sore throat, shortness of breath, runny nose, or loss of taste/smell.
_____ I confirm I have not traveled internationally or on public transportation in the last 14 days.
_____ I understand that despite preventative measures, there is a risk of COVID-19 exposure during treatment.
_____ I accept this risk and consent to care at Dragon Rises College of Oriental Medicine.

By signing below, I acknowledge I have read and understand this waiver, had the opportunity to ask questions, and voluntarily consent to treatment. This consent applies to today and all future visits unless revoked in writing.

Patient Name ______________________________ Date:______________

Patient Signature ____

Parent Guardian Signature______________________ Date:______________

Witness Name ______________________________ Date: ______________

Witness Signature____

ONGOING VISITS: PATIENT INITIALS & DATES : (CONFIRMING NO SYMPTOMS & CONTINUED CONSENT)

Date:_______	**Patient Initials:** _________	**Date:**_______	**Patient Initials:** _________	**Date:**_______	**Patient Initials:** _________
Date:_______	**Patient Initials:** _________	**Date:**_______	**Patient Initials:** _________	**Date:**_______	**Patient Initials:** _________
Date:_______	**Patient Initials:** _________	**Date:**_______	**Patient Initials:** _________	**Date:**_______	**Patient Initials:** _________
Date:_______	**Patient Initials:** _________	**Date:**_______	**Patient Initials:** _________	**Date:**_______	**Patient Initials:** _________
Date:_______	**Patient Initials:** _________	**Date:**_______	**Patient Initials:** _________	**Date:**_______	**Patient Initials:** _________
Date:_______	**Patient Initials:** _________	**Date:**_______	**Patient Initials:** _________	**Date:**_______	**Patient Initials:** _________
Date:_______	**Patient Initials:** _________	**Date:**_______	**Patient Initials:** _________	**Date:**_______	**Patient Initials:** _________