Consent for Treatment by Traditional Chinese Medicine

I, the undersigned hereby authorize Kristine Buckley, L.Ac, MTCM, licensed Acupuncturist in the State of California (Lic # AC 11544) to perform Chinese Medicine treatment methods which may include acupuncture, microcurrent, color light therapy, moxibustion, cupping, gua sha, bleeding, herbal therapy, and dietary and lifestyle advice.

I understand that these treatments are all safe, natural methods of healing and I recognize the potential risks and benefits of these procedures as described below:

POTENTIAL BENEFITS: Relief of presenting symptoms, improved health and wellbeing, reduced stress and an overall balance of bodily energies which may lead to prevention or elimination of your main complaint(s).
POTENTIAL RISKS: Acupuncture - Although uncommon, there is a potential for acupuncture to cause temporary bruising, swelling, bleeding, numbness, tingling, and soreness at the needle site that may last a few days. Unusual risks of acupuncture include dizziness, fainting, nerve damage or possibly the aggravation of symptoms existing prior to treatment. Infection is a slight possibility even though our clinic uses only sterile disposable needles and maintains a clean and safe environment.
Moxibustion - Burning of moxa (a Chinese herb – Mugwort) on or near the body has the potential risk of burns, blistering or scarring. ***Cupping and Gua Sha*** - may cause temporary bruising or redness lasting a few days. ***Herbal Medicine*** - Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions. Large doses taken without my practitioner's approval may be toxic and some herbs may be inappropriate during pregnancy.
Microcurrent &/or Color Light Therapy - *Potential Benefits:* relief of presenting symptoms, improved health and wellbeing, reduced stress and an overall balance of bodily energies which may lead to prevention or elimination of my main complaint. *Potential Risks: Microcurrent:* Although uncommon there is a possibility of adverse reactions such as skin burns or irritation if I have sensitive skin, especially in long term application, hematoma, bruise, puffiness, headache, lightheadedness, redness, temporary aggravation, pain or other symptoms. *Color Light Therapy:* contraindicated in migraines or seizures triggered by flashing lights.
PREGNANCY: Acupuncture can be very beneficial in the treatment of symptoms during pregnancy, assisting in the birthing process and postpartum. I will notify my acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points or herbs that could induce premature labor or miscarriage.

CANCELATION POLICY: I recognize that scheduling an appointment involves the reservation of time specifically for me and I agree to give at least 24 hours notice to cancel or reschedule an appointment. A no-show fee of $30 will be charged for sessions missed without such advance notification.

With this knowledge, I voluntarily consent to the above procedures and policies, realizing that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments regarding the cure or improvement of my conditions. I hereby release Kristine Buckley from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participating in these procedures at any time.

____ ____/____/____
Print Patient Name   Signature of Patient or Guardian   Date

Financial Policy

Trinity Healing makes every attempt to make alternative health care, as Traditional Chinese Medicine, available to as many people as possible.

In respect for our intention to offer high quality health care to our community, we ask for 24 hours notice in advance of an appointment if you need to cancel our reschedule an appointment.

All appointments that are rescheduled or cancelled with less than 24 hours advance notice, and appointments missed without notice, will be charged a $30.00 fee for that appointment. If appointments have been purchased in a package, the missed, cancelled or rescheduled appointment will be deducted from the number of remaining appointments in that package.

Thank you for your understanding.

Trinity Healing

Signature:____
Date:_________________

Printed Name:____

Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by Trinity Healing for the purposes of diagnosis or providing treatment or to conduct health care operations. I understand that diagnosis or treatment of me at Trinity Healing may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment or health care operations of the practice. Trinity Healing is not required to agree to the restriction I may request. However, if Trinity Healing agrees to a restriction that I request, the restriction is binding upon Trinity Healing.

I have the right to revoke this consent, in writing, at any time except to the extent that Trinity Healing has taken action in reliance on this consent.

My identifiable health information means information, including my demographic information, collected from me and created or received by my practitioner or another health care provider. This identifiable health information relates to my past, present or future physical or mental health or condition, and identifies me, or there is a reasonable basis to believe the information may identify me.

____

Signature of Patient or Authorized Representative

Date:_____________

REGISTRATION FORM

Name____ **Date**______________

Address

____
Street **APT#** **City** **State** **Zip**

Telephone_______________ _________________ ______________________
Home **work** **cell**

Email____

Date of Birth ________/_______/________ **Sex:** ☐**Male** ☐**Female**

Where or from whom did you learn about Trinity Healing?

Primary Care Physician: ____

Phone: ____________________

Occupation: ____

Company Name: ____

Emergency Contact: ____

Relationship: ________________________

Address:

____
Street **APT#** **City** **State** **Zip**

Telephone:_______________ _________________ ______________________
Home **work** **cell**

Signature____

Date_____/_____/

Medical History

Name:____ Date: ____/____/____

What is the reason for this visit?

____

Date of onset? ____/____/____

Have you had this in the past? ☐ No ☐ Yes, Speify:

____

Is this condition: □ Improving □ Consistent □Getting Worse

What makes it feel better: □ Movement □ Rest □ Heat □ Cold □Other:________________

What makes it feel worse: □ Movement □ Rest □ Heat □ Cold □Other:________________

If there is pain, is it: □ Mild □ Moderate □ Severe □ Sharp □ Dull □ Achy

On a scale of 1 (no Pain) to 10 (worse pain), your pain rates a number: ____________

Family Medical History:

Do you have a family history of any of the following conditions?
□Diabetes □ High Blood Pressure □ Stroke

□ Cancer □ Heart Disease □ Allergies
□Other:____

Medical History: Check the appropriate box that pertains to your health history

Condition		Condition	
Cancer	□ yes, Date: ____/____/____	Allergies	□ yes, Date: ____/____/_
Diabetes	□ yes, Date: ____/____/____	Heart Disease	□ yes, Date: ____/____/_
Hypertension	□ yes, Date: ____/____/____	Stroke	□ yes, Date: ____/____/_
Hepatitis	□ yes, Date: ____/____/____	High Cholesterol	□ yes, Date: ____/____/_
Asthma	□ yes, Date: ____/____/____	Thyroid Disorder	□ yes, Date: ____/____/_
Immune Disorders	□ yes, Date: ____/____/____	Other	Date: ____/____/____

Are you pregnant?	Are you trying to conceive?
□ Yes □ No	□ Yes □ No

Name: ____

DIGESTION

□ No Appetite □Low Appetite □High Appetite
□ Nausea □ Vomiting □ Gas
□ Bloating □ Bad Breath □ Belching
□ Indigestion
□ Abdominal Pain Related to Eating:
□ Before □ After

□ Weight Gain □ Weight Loss
□ Heart Burn □ Ulcers

Do you crave: □ sweet □ salty □sour
□ spicy □ Bitter foods

INTESTINES

How often do you have a bowel movement?
per day __________ OR # per week ________
□ Constipation
□ Diarrhea
□ Loose Stools □Undigested food in stool
□ Hemorrhoids
□ Rectal Bleeding: □Red □Brown □Black

Stool is: □Urgent □Dry □Hard
□Pebble-like □Watery
□ Difficult to Pass

ENERGY LEVEL

□ Too much
□ Not enough to get through the day
□ Right amount to complete daily activities

SLEEP

□ Restful
□ Insomnia □ Problem falling asleep
□ Problem staying asleep
□ Nightmares
□ Dream- disturbed sleep
How many hours do you sleep? ______/nite

BODY TEMPERATURE

□ Cold Hands □ Cold feet
□ Most of the time, do you feel:
□ cold overall □ hot overall □normal
□ Chills
□ Feel hot in □palms □feet □chest
□ Alternating between hot and cold
□ Fever, Temp. ______ for how long? ______
□ Excess Thirst
Do you prefer: □ cold drinks □hot drinks
□ room temperature

SWEATING

□ Night sweats
□ Profuse Sweating
□ Sweat easily with little activity
□ Sweaty hands
□ Sweaty feet

EYES/EARS/NOSE/THROAT

□Ringing in the ears: □high OR □low pitch
□ Ear pain □ Hearing Loss
□ Dry Eyes □Blurred Vision
□ Floaters
□ Runny Nose □Sneezing □Sinus Congest
□Frequent colds/URIs □Sore Throat
□Nose Bleeding □ Gums Bleeding
□Grinding Teeth

MOUTH/CHEST/RESPIRATORY

□Shortness of Breath
□ Wheezing
□ Dry cough: □night □day □all the time
□ Productive Cough with Phlegm:
Color:_______________ □thin □thick
□ Chest: □Pain □Distention
□ Rib Pain
□Palpitations

Name: ____

NEUROLOGICAL	URINARY SYSTEM
□ Headaches: How Often? _______________ Where? ________________________________ Known Causes? _________________________ □ Dizziness □ Vertigo □ Memory Loss □ Seizures If □ Tremors □ Numbness □ Tingling Where?_______________________________	□ Frequent Urination □Day □Night □All day □ Difficult Urination □ Dribbling □ Incontinence □ Burning Urination □ Blood in Urine □ Frequent Urinary Tract Infections
EMOTIONS	**PERSONAL HABITS**
□ Anxiety □ Easily Angered □ Irritable □ Nervous □ Moody □ Depressed □Manic □ Cry Easily □ Fearful □ Grieving	Do you: □ smoke: How much? __________________ □ Drink alcohol: How many glasses/wk ______ □Drink Coffee: cups/day _____________ □ Drink Tea: Cups/day ______________ □ Exercise: □ Everyday OR Times/wk ______ Type of Exercise:________________________ _______________________________________ ___
FEMALE	**HEALTH**
Date of Last Period:____/____/____ # of Days Period Lasts: ______________ # of Days Between Periods: _____________ Are your periods regular? □ Yes □No Color: □Red □ Bright Red □ Dark Red □ Pale □ Brown Consistency: □ thick □ Thin □ Pass clots □ Cramps: □ Before, How many days? ______ □ During, How many days? ______ □ Better with heat □ Better with rest	□ Breast Tenderness □ Mood Changes □ Food Cravings □ Low Back Pain □ Spotting Between Periods □ Hot Flashes □ Vaginal Dryness □ Libido: □ Too Low □ Too High

Medications/Supplements	Dose	How Often

Thank you for choosing Trinity Healing!

DIRECTIONS TO TRINITY HEALING:

From Valley Ave, turn onto Quarry Lane
Stay Straight on Quarry Lane
You will see Serpentine Lane coming up on your right. DO NOT TURN ONTO SERPENTINE LANE!
Go past Serpentine Lane, and take your FIRST DRIVEWAY ON THE RIGHT
Park Immediately
My office is in the Evoke Wellness Center, in the back on 1020 Serpentine Lane and on the corner of Quarry and Serpentine

OTHER BUT IMPORTANT STUFF:

Wear comfortable clothes. If you want to wear skinny jeans, please be sure to bring loose fitting pants to your appointment.

You are more than welcome to bring your own music to listen to during your treatment.

I will be sure to make you as comfortable as possible during your time in my clinic.

I look forward to meeting you and working with you!