MEDICAL HISTORY—SYMPTOM CHECKLIST

CHECK ANY CURRENT CONDITIONS OR THOSE THAT YOU HAVE HAD IN THE PAST
(please write the word "Past" next to those conditions which you have ONLY had in the past and which are no longer present)

PATIENT CONFIDENTIAL INFORMATION

Name_____
First Middle Last

Address_____
Street City State Zip

Home Phone_____ Cell Phone_____

Work Phone _____ E-Mail Address _____

Age_____ Date of Birth ____/____/____
MM DD YY

Current Gender Identity: _____ Preferred Pronoun: _____

Emergency contact: _____
Name Relationship Phone #

_____
Street City State Zip Code

Primary language spoken at home: _____

*Place of Birth_____ * Marital Status S M D W

*Occupation or profession_____ *Employer _____

*Where did you hear about us? _____

**This information is helpful, but optional. All other information is mandatory.*

PATIENTS PLEASE FILL IN: **Name**: _____ **Date**: _____

INTERN CLINIC TERMS AND CONDITIONS OF SERVICE

TREATMENT OF MINORS

During the treatment of patients under 18 years of age, the patient's legal guardian must be present in the clinic during the entire session for each treatment. Please speak to the front desk for details.

INSURANCE AND WORKERS COMP

We will only prepare insurance billing information for patients paying our standard fee. Billing information is prepared after every fifth visit. Emperor's College does not treat worker's compensation injuries.

ECTOM 24-HOUR CANCELLATION POLICY

In order to maintain the integrity of our low-cost community treatment clinic, Emperor's College must request that all cancellations be made with a minimum of 24-hour notice. Appointments and cancellations must be made with the front desk only. Failure to provide 24-hour notice or a failure to show will result in your account being charged for the visitation *at our standard fee*. This means that low income patients and Emperor's College students and staff *will also be charged the standard fee* for late cancellations or not showing up to an appointment. Last minute cancellations and failures to show affect our ability to serve both our community and our interns. Also, there are NO refunds given or returns on any herbal products that are purchased.

OBSERVERS

Given that Emperor's College Clinic is a teaching clinic; all patients must assume that an observer will be present during the course of their appointment. Emperor's College charges a reduced fee because we are a teaching clinic. Patients who refuse to allow an observer can be denied service.

SEXUAL HARASSMENT

Be advised that interns and student observers attending Emperor's College Clinic do so in pursuit of an education only. All comments or questions from patients regarding an intern's or student observer's appearance, dating habits or personal life are not permitted. Any complaint regarding a violation of this policy will result in that patient being barred from this facility. We have high expectations of professionalism from our interns and student observers and expect the same of our patients. We will vigorously protect the intern's and student observer's right to pursue their education in an environment completely free from all harassment.

ADMISSION AND MEDICAL SERVICES AGREEMENT

The patient or the patient's representative consents to the admission of the patient to Emperor's College Teaching Clinic if this is deemed necessary for the care of the patient. All the terms and conditions hereof shall also apply to such admissions.

MEDICAL CONSENT

I have read and fully understand that Emperor's College Intern Clinic is a teaching clinic. I understand that interns and Oriental Medical students as observers and post-graduate fellows under the supervision of attending Practitioners of Oriental Medicine (Licensed Acupuncturists) are participating in my treatment procedures as part of the medical education program of the institution. Under this condition, the patient or the patient's representative consents to any Oriental Medical treatments or procedures that are given by the Interns under the general and special instructions of the attending practitioner or any other Practitioner of Emperor's College Teaching Clinic assisting in the care of the patient. The patient accepts the full responsibility to follow up the medical advice given at Emperor's College Teaching Clinic.

The patient or the patient's representative consents to the treatment procedures and its results and repercussions thereof and accepts arbitration if deemed necessary.

RELEASE OF INFORMATION
Emperor's College Teaching Clinic will, only through a patient completing a specific and separate Authorization for Release of Information form, or in compliance with a legal subpoena, furnish from the patient's record necessary information to the referring physician, if any, and to others to the extent required in connection with a claim for aid, insurance, or medical assistance to which the patient may be entitled.

SUPERVISORS SUBJECT TO CHANGE
As a teaching clinic with numerous supervisors and the circumstances involving the availability of any supervisor at any one time sometimes changing, the supervisor originally scheduled for being present on a particular shift may not be available—this change in scheduling may even occur at the last minute. As such, although every effort will be made to keep the schedule as consistent and predictable as possible, Emperor's College Community Clinic does not guarantee that a particular supervisor will be available at the time of a treatment. We reserve the right to replace a supervisor at any point in time with another qualified supervisor who fulfills our high standards for experience and knowledge. In the event that a supervisor is replaced on a particular shift, patients will not be given an exception to allow a last minute cancellation of their appointment without consequence and will not be given a refund.

PATIENT RESPONSIBILITIES
As a patient of Emperor's College Acupuncture Clinic, it is important that you are not intoxicated or under the influence of any type of medication or drug, medically-prescribed or recreational, at the time of your treatment. This policy exists for the safety of our patients, as the effect of acupuncture on the nervous system of an individual in such a state is unpredictable and potentially dangerous. If it is determined by the supervisor, intern, or clinic staff that you are in such a state, you will be denied treatment and will be asked to leave. If this happens repeatedly, we reserve the right to bar any such patient from scheduling appointments in the future.

We train our faculty, students and staff to behave professionally and respectfully in regard to all patients and expect them to exhibit this behavior at all times. Similarly, we expect our patients to behave with respect and consideration to our faculty, students and staff. If a patient exhibits repeated episodes of inappropriate, disrespectful, belligerent or strongly rude behavior to any faculty, students or staff, we reserve the right to bar said patient from returning to the clinic for future treatments. We also request that any instances of inappropriate or unprofessional behavior on behalf of the faculty, students or staff be reported immediately to the Dean of Clinical Education, his assistant, or the Clinic Manager.

As this is a teaching clinic, students have a required protocol *on every visit* that can include asking numerous questions about all aspects of a patient's functions and body systems; also, several basic vital signs must be measured *every visit* for both instructive purposes and medical safety of patients: blood pressure, temperature, heart rate and weight (and height on certain visits). You can be denied service and asked to leave if you refuse to cooperate with this process. Also, if you are found to have signs or symptoms of any problem that is so severe that an urgent western medical intervention is considered necessary by our supervisor, you will be denied treatment and strongly urged to go to a hospital emergency room.

FINANCIAL AGREEMENT
At the time that services are rendered, the patient or patient's representative shall pay the Emperor's College of Teaching Clinic for services rendered in accordance with the regular rates and terms of the Emperor's College Teaching Clinic. When this agreement is executed by the patient or the patient's representative or a financial guarantor, all shall be jointly and individually liable for the patient. Should accounts be referred to an attorney or collection agency, reasonable attorney's fees and collection expenses incurred shall be payable in addition to the other amounts due. Additionally, *all sales on herbs are final: there are NO refunds or returns on any herbal products*.

The Emperor's College Teaching Clinic and the patient's representative hereby enter into this agreement. The patient or the patient's representative certifies that he/she has read and accepted the "Terms and Conditions of Service"

X_____ _____
Signature of Patient Date Signature of Representative Date

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, ECTOM Clinic, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to ECTOM Clinic's Notice of Privacy Practices for a more complete description of such uses and disclosures. (This allows your information to be used for clinic and teaching purposes only! We will not release this information unless we receive a subpoena or "authorization to release" signed by you.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. ECTOM Clinic reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to ECTOM Clinic Privacy Officer at 1807-B Wilshire Blvd., Santa Monica, Ca 90403.

ECTOM Clinic may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

ECTOM Clinic may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

ECTOM Clinic may e-mail to my appointment reminder cards and patient statements. I have the right to request that ECTOM Clinic restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to ECTOM Clinic's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, ECTOM Clinic may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

MEDICAL HISTORY QUESTIONNAIRE

Please complete the following as accurately as possible.

Patient Name: _____ Date: _____

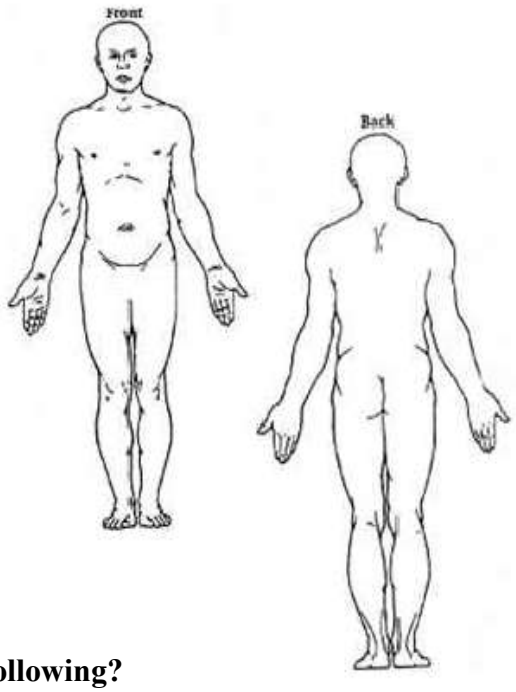
Present Illness:

What is your chief complaint?

When did this condition begin?

What treatment have you received already?

Mark below with an X where you feel pain or discomfort.



Medical History:

What surgeries have you had? When did you have them?

What other serious injuries or illnesses have you had?

Do you have any allergies that you know of?

What medications are you taking?

Which, if any, of your blood relatives have had any of the following?

☐ Stroke ☐ Cancer ☐ Heart Disease ☐ Tuberculosis ☐ Bleeding disorders
☐ Diabetes ☐ High blood pressure

Please list your primary physician's name and contact information:

Name: _____ Phone: _____

Address: _____

Specialty, if any: _____

Menstrual History:

Age of your first period:_____
Vaginal discharge:_____
Length of cycle, day 1 to day 1_____
Length of flow (days):_____
Date of your last period:_____
Do you believe you are pregnant? Yes___ No__
Number of pregnancies: _____
Number of live births: _____

Recreational Substance Usage:

History of smoking?____ How many years?____
--how many per day?_____
History of smokeless tobacco use?_____
History of drinking alcohol?_____
--how many drinks/week?_____
History of recreational drug use?_____
How many cups of coffee/day? _____
How many sodas/day? _____

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CHECK ANY CURRENT CONDITIONS OR THOSE THAT YOU HAVE HAD IN THE PAST
(**please write the word "Past" next to those conditions which you have ONLY had in the past and which are no longer present**)

HEAD AND NECK:
____ **Dizziness***
____ **Fainting***
____ Neck Stiffness
____ Enlarged lymph glands
____ Headaches
_____ Other

EARS:
____ Infection
____ Ringing
____ Decreased hearing
_____ Other

EYES:
____ Blurred vision
____ Visual changes
____ Poor night vision
____ Spots/Floaters
____ Eye inflammation/Styes
_____ Other

NOSE, THROAT & MOUTH:
____ Bleeding
____ Sinus infection
____ Hay fever or allergies
____ Sore throat
____ Hoarseness
____ Changes in taste
____ Difficulty swallowing
____ Changes in smell
____ Oral ulcers/Canker sores
_____ Other

SKIN:
____ Hives
____ Rashes
____ Eczema
____ Psoriasis
____ Seborrhea
____ Night sweating
____ Excess sweating
____ Dryness
____ Bruises easily
____ Changes in moles or lumps
_____ Other

NEUROLOGICAL:
____ Numbness or tingling of limbs
____ **Seizures***
____ Tremors
____ Pain
____ Paralysis
____ **Epilepsy or Convulsions***
_____ Other

INFECTION HISTORY:
____ HIV/AIDS, or HIV risks: Self or partner
____ TB: Self or household
____ **Hepatitis, or Hepatitis risk:**
Self/Partner*
____ History of sexually transmitted diseases: Self or partner:
____ Gonorrhea
____ Chlamydia
____ Syphilis
____ Genital warts
____ Herpes (oral) ____ Herpes (genital)
____ **MRSA, Staph, CRE, or other Drug-Resistant Infections***

RESPIRATORY:
____ Chronic cough
____ Coughing up blood
____ Coughing up phlegm frequently
____ Difficulty breathing
____ Wheezing/Asthma
____ Frequent Colds
____ Emphysema
____ Pneumonia repeatedly
_____ Other

CARDIOVASCULAR:
____ Palpitations
____ Chest pain or tightness
____ Rapid heart beat
____ Irregular heart beat
____ Heart Disease
____ Poor circulation
____ Swelling of ankles
____ Phlebitis
____ Cold hands/feet
____ **Cardiac Pacemaker***
____ **High blood pressure***
____ **Stroke***
_____ Other

GASTROINTESTINAL:
____ Indigestion
____ Nausea
____ Stomach pain
____ Irritable bowel disease
____ Colitis
____ Crohn's Disease
____ Pancreatitis
____ Celiac Disease
____ Recent change in bowel habits
____ Diarrhea (___ stools/day)
____ Constipation (___ stools/week)
____ Dry, hard stools
____ Soft, difficult, sticky stools
____ Irregularly or poorly-formed stools
____ Poor appetite
____ Excessive hunger
____ Blood in stool or black stools
____ Hemorrhoids
____ --with pain or blood
____ Gall bladder disorder
____ Vomiting blood
____ Peptic Ulcer
____ Recent change in weight
____ Food cravings
_____ Other

MUSCLES AND JOINTS:
____ Joint disorder
____ Sore muscles
____ Weak muscles
____ Difficulty walking
____ Spinal curvature
____ Backache
____ Back pain
____ Fibromyalgia
_____ Other

MALE:
____ Pain/itching of genitalia
____ Genital lesions/discharge
____ Impotence
____ Premature ejaculation
____ Prostate problems
____ Infertility (e.g., abnormal sperm)
_____ Other

FEMALE:
____ Frequent vaginal infections
____ Infertility
____ Pain/itching of genitalia
____ Genital lesions/discharge
____ Pelvic inflammatory disease
____ Abnormal Pap smear
____ Irregular periods
____ Emotional changes with menses
____ Clots with menses
____ Painful menstrual periods/cramps
____ Premenstrual Syndrome
____ Abnormal bleeding
____ Menopausal symptoms (hot flashes, etc.)
____ Breast lumps/cysts
____ Breast swelling and/or pain
_____ Other

URINARY:
____ Frequent urinary tract/bladder infections
____ Weak urinary stream
____ Recent change in bladder habits
____ Kidney Disease
____ Frequent day urination (___ X)
____ Frequent night urination (___ X)
_____ Other

GENERAL:
____ Fatigue
____ Thirst
____ Aversion to cold
____ Insomnia
____ Frequent dreams/nightmares
____ Depression
____ Agitation
____ Irritability
____ Anxiety
____ History of psychiatric treatment
____ Poor memory
____ Difficulty concentrating
____ **Sores that don't heal***
____ Congenital abnormalities
____ **Surgical implants***
____ Unusual bleeding or discharge
____ Jaundice
____ Hernia
____ Epstein Barr virus (EBV)
____ Rheumatic Fever
____ **Diabetes mellitus***
____ Thyroid Disorder
____ Cancer
____ **Anemia or other blood disorder***
____ Lupus erythematosus
_____ Other

PATIENTS PLEASE FILL IN: **Name**: _____ **Date**: _____