Susan Samueli | Integrative Health Institute

MR#: _____

Name: _____ Date: _____

Age: _____ Sex: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-M ail: _____

Married
Divorced
Widowed
Single
Separated

Occupation: _____

Employer: _____

Address: _____

Primary Care Physician: _____

Address: _____ Phone: _____

Referral Source: _____

Emergency Contact: _____ Phone: _____

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Consent

I_____, consent and agree to the Treatment and Supplements recommended for me by the practitioners at the Susan Samueli Integrative Health Institute from the following choices:

General Diagnostic Procedures – including physical exams, neurological and musculoskeletal assessments, tongue and pulse assessment.
Lifestyle Counseling and Exercise Prescriptions.
Herbs/Natural Medicines– prescription of various therapeutic substances including plants, minerals, and animal materials. Substances may be given in the form of tea, pills, powders, essences, essential oils, tinctures (may contain alcohol), plasters, and topical creams.
Dietary Advice and Therapeutic Nutrition – use of foods, diet plans, and nutritional supplements. Soft Tissue Therapy – use of tui na and acupressure.
Electric/Infrared/Ultraviolet Therapies – includes the use of low volt electroacupuncture, transcutaneous stimulation, microcurrent stimulation, electromagnetic wave therapy, and infrared and ultraviolet therapies.
Acupuncture – insertion of specialized sterile needles through the skin into underlying tissues at specific points on the surface of the body.
Cupping – a technique used to relieve symptoms in which cups made of glass are placed on the skin with a vacuum created by heat or other device.
Gua Sha – rubbing on an area of the body with a blunt, round instrument. Laser Therapy
Manual soft tissue and joint therapy Exercise & posture training

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progress. Results cannot be guaranteed. Research has shown acupuncture to be effective in approximately 70% of the general population.

Potential risks: 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. 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 spontaneous miscarriage, 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. 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.

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Adjunctive Care: Our practitioners solely provide adjunctive care and are not available after business hours. If you experience an adverse reaction to any recommended supplements or treatment, please immediately contact our practitioners during business hours. If our practitioners cannot be reached, please discontinue the supplements and leave a voicemail.

You will be contacted on the next working day. If you are experiencing an acute condition, severe, adverse reaction, or emergency situation, please either contact your primary care physician or call 911immediately. You are expected to have a primary care medical physician follow your care at all times. Our practitioners are not responsible for any hospital coverage, after hour, weekend, or general medical care you may seek.

History:

Completely fill the Wellness History Form.

Alert our practitioners if you suspect or know that you are pregnant since some of the therapies could present a risk to pregnancy. Our practitioners do not use labor-stimulating acupuncture points or any labor-inducing substances unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

Alert our practitioners if you have a cardiac pacemaker since electro-therapies may be contraindicated in this case.

Photographs may be taken before, after, and with each follow-up visit/treatment.

I understand the Benefits, Risks, Limitations, and Precautions described herein. I will abide by all instructions and precautions in order to achieve optimal results. I take full responsibility for my health during treatments and hold the practitioners free from any legal actions. The maximum damages in case of any valid dispute will be the refund of my treatment fees. I voluntarily consent to the recommended treatment and/or supplements realizing that no guarantees have been given to me by the practitioners regarding the cure or improvement of my condition. I have read the above information and have had all my questions answered to my satisfaction.

Name:_____ Signature:_____ Date:____/____/____

Witness Name:_____ Signature:_____ Date:____/____/____

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Informed Consent Regarding Nutritional and Herbal Supplements

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201(g)(1), the term *drug* is defined as an “article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease.” Technically, vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient’s diet and to supply nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

Sale of Nutritional Supplements at *the Susan Samueli Integrative Health Institute*

You are under no obligation to purchase nutritional supplements at our clinic.

As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements that we carry in our facility are those that meet our high standards and tend to produce predictable results.

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

If you have concerns about this issue, please discuss them with our staff.

I,_____, have read and understand the above statement.

SIGNATURE:_____ DATE:_____

WITNESS:_____ DATE:_____

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Informed Consent for Hormone Replacement Therapy

Hormone replacement therapy (HRT) is often prescribed to women during perimenopause (the time from first symptoms to up to several years beyond the last period) and menopause (starting one year after the last period) for symptoms of hot flashes, vaginal dryness, loss of libido, depression, irritability or PMS-like symptoms, bone loss and osteoporosis or its prevention, and cardiovascular disease. HRT is approved by the FDA only for hot flashes and osteoporosis. Using it for other symptoms or problems is considered "off-label" use, and the burden is on the physician to be sure that there is adequate science to support the use in a given situation. Needless to say, there will be differences of opinion about how much science is necessary.

Because of the rapidly changing ideas about the safety and effectiveness of hormone therapy for anything other than birth control, I feel it is important to be sure that you have information about the risks and benefits of hormone therapy before you take the therapy we have discussed.

It is now thought that the combination of estrogen and progestogens increases the risk of breast cancer over estrogen alone.

Estrogen replacement therapy (ERT) is used primarily for women who have had their uterus removed and for whom estrogen alone does not cause negative symptoms. Use of estrogen alone in the doses most often prescribed in America increase the risk of uterine cancer. In very low doses, estrogen alone may be used without progestogen (progesterone or artificial progestins such as Provera) if adrenal function is healthy. In this case, there is a risk of bleeding, endometrial hyperplasia, or cancer, and you should discuss this with your doctor.

When hormone levels are brought back to "normal" for your age, there is much evidence that your overall health benefits. The risk of osteoporosis and fractures decreases. HRT is the most effective treatment for hot flashes. There may be other long- term beneficial effects of treatment. If your (female sex) hormones are already normal, adding additional hormone to address symptoms such as hot flashes may increase your risk of diseases like cancer or problems like blood clotting.

The current medical thinking is always changing, so it is important to discuss HRT with your doctor each year at your annual exam to find out what the latest thinking is.

Please read the following and sign:

I have discussed the reason for taking female sex hormones with my doctor and understand why he/she is prescribing them and the risks associated with taking hormones, including but not limited to the possibility of an increased risk of breast or endometrial cancer, blood clotting, stroke, or heart attack.

I understand that there are different risks if I take progestogens or testosterone, and they may be higher or lower than taking estrogen alone. I have discussed this risk and the reasons for taking them with my doctor.

I understand that my doctor will do everything he/she knows to do to decrease and minimize the risks of HRT but that there are no guarantees that these measures will be effective at preventing the negative side effects mentioned above or others that we do not yet know about.

I accept the risks and unknowns of taking hormone therapy and wish to have my doctor prescribe them for me.

Signature:_____ Date:_____

I WILL NOT BE RECEIVING HORMONE REPLACEMENT THERAPY

Name:_____ Date:_____

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CANCELLATION POLICY FOR SERVICES

As part of our effort to provide you with the best of care and accommodate all appointment requests, we have a cancellation policy. We appreciate your business and know that your time is as valuable as ours. By extending the courtesy of a timely notice of cancellation or intent to reschedule you afford us the ability to provide a greater availability of our services for patients who have an urgent need for care.

If you are aware of your need to reschedule or cancel, more than 24 hours prior to your appointment, we encourage you to send us a message through our patient portal (MyChart). Our front office team checks messages daily. We can communicate directly back to you through this secure, private connection and provide you a new appointment. MyChart allows you to send communication to our front office and back office support teams, as well as your providers, when it is most convenient for you, anytime of day or night. Urgent messages are replied to within 1 business day and non-urgent messages within 3 business days.

If you need to cancel or reschedule on the same day or notify us that you will be unable to arrive 20 minutes prior to your scheduled appointment for the required registration and medical assistant intake process, please call 714-424-9001. We are committed to helping you receive the full appointment time with your provider, but ask that you provide us 20 minutes of your time, prior to your appointment, to complete your registration and intake process.

To assist you with keeping your scheduled appointments, we provide our patients courtesy appointments reminders, 3 business days in advance, through both an automated service and through a message on MyChart, our patient portal.

Excessive cancellations or no- shows for scheduled appointments may result in discharge from our practice.

I have read the above cancellation policy and agree to its terms and conditions:

Name:_____ Date: _____

Signature:_____

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Patient History Form

Name: Age: ___

Present Health Concerns (in order of importance): Duration:

1. _____ _ __ ___
2. _____ _ __ ___
3. _____ _ __ ___

MEDICAL/HEALTH HISTORY:

Current Health Provider(s):	Phone:	Reason for seeing:
_____	(___)_____	_____
_____	(___)_____	_____
_____	(___)_____	_____

Date last full physical exam: _____ Results: normal other (_____)
Date last labwork and urine test: _____ Results: normal other (_____)
Date last prostate exam (males): _____ Results: normal other (_____)
Date last PAP and pelvic exam (females): _____ Results: normal other (_____)
Date last mammogram (females): _____ Results: _____
Date last DEXA or bone imaging (females): _____ Results: _____

Surgeries and Hospitalizations with Dates: _____

Illnesses and Injuries with Dates: _____

Allergies (drugs, food, environmental). Please circle any, if life-threatening: _____

Prescription Drugs (include dosage): PLEASE USE MEDICATION FORM ATTACHED

Supplements: PLEASE USE MEDICATION FORM ATTACHED

Previous Integrative Treatments: _____

MEDICAL/FAMILY HISTORY:

Condition	Self/Family Member
Allergies	
Alcoholism	
Anemia	
Rheumatoid Arthritis	
Osteoarthritis	
Diabetes	
Cancer ( )	
High Cholesterol	
Epilepsy	
Heart disease	

Condition	Self/Family Member
Kidney disease	
Mental disorder	
Obesity	
Stroke	
Thyroid (low/high)	
Osteoporosis	
Fractures (Mom/Grandma)	
Autoimmune Disease	
Bleeding Tendency	
High Blood Pressure	

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SOCIAL HISTORY

Personal Habits (Please List Current or Past Use, Frequency, and Quantity):
Tobacco: _____ Caffeine: _____ Alcohol: _____ Recreational Drugs: _____

EXERCISE: List Type of Activities: _____ Frequency per week: _____

REVIEW OF SYSTEMS (please circle if you are experiencing any of the following symptoms):

Hematologic:	Gastrointestinal:	Cardiovascular:	Genitourinary:	Gynecological:
Anemia	Bad breath	Stroke	Kidney Infection,/UTI	Menopause
Blood diseases	Constipation	Nosebleeds	KD disease/Stones/Blood in urine	Breast lump/discharge
Fatigue, Dizziness	Heartburn/ Ulcers	Varicose veins	Frequent/night time urination	PMS
Bleeding/bruising	Hepatitis/Jaundice	High/Low blood pressure	Incontinence	Age period started: _____
Blood clots	Diarrhea	Chest pain	Frequent, night time urination	LMP _____
Skin/Nails:	Nausea, Vomiting	Heart Disease	Testicular pain/mass	Periods last _____ days
Skin rash/hives	Bitter taste in mouth	Irregular heart beat	Prostate problem	Periods come every ____ days
Brittle Nails	Rectal itching	Swelling/edema	Sexual dysfunction	Pain with periods
HEENT:	Hemorrhoids	Cold hands/feet	STD _____	Heavy menstrual bleeding
Headaches	Burping	Varicose veins	Systemic Review:	No. of pregnancies _____
Hearing loss	Gas/Bloating	Neuro-psychiatric:	Hot flashes	No. of children _____
Ringing in the ears	Cramping	Tingling, numbness	Excessive sweating	No. of miscarriages _____
Eye pain/Itchy eyes	Laxative use	Weakness	Excessive thirst	No. of abortions _____
Sore throat/allergies	Blood in stools	Eating disorder	Fever/chills	Vaginal discharge/itching
Sneezing/runny nose	Frequency of BM _____	Seizures	Respiratory:	Currently pregnant? Yes/No
Nosebleeds	Consistency of stool _____	Paralysis	Tuberculosis	Endocrine:
Sinusitis/allergies	Musculoskeletal:	Poor balance	Asthma/wheezing	Hair loss/thinning
Jaw pain(TMJ)	Difficulty walking	Poor memory	Difficulty breathing	Dry skin
Mouth/tongue sores	Muscular pain/weakness	Poor concentration	Cough	Hormone therapy
Catches colds easily	Joint pain/stiffiness	Depression, anxiety	Pneumonia	

Sleep: Hours/night: _____ Bedtime: _____ Waketime: _____

Do you have problems with: T Staying asleep T Falling asleep T Other sleep issues _____

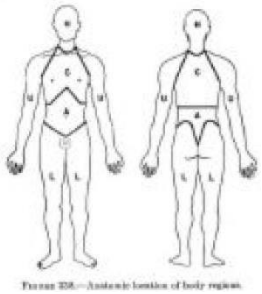
Do you wake up at night? If yes, how often and at what times does this happen? _____

Energy level (average per week, circle one): (lowest energy) 1 2 3 4 5 6 7 8 9 10 (highest energy)

Stress level (average per week, circle one): (lowest stress) 1 2 3 4 5 6 7 8 9 10 (highest stress)

Sources of stress: _____ How do you cope with stress? _____

Pain Scale (circle areas and level of pain): (lowest pain) 1 2 3 4 5 6 7 8 9 10 (highest pain)



Please check all that apply: Pain is: T Dull T Sharp

Diet History (include any liquids, tea, coffee, etc.):

Breakfast yesterday: _____ AM Snack foods: _____

Lunch yesterday: _____ PM Snack foods: _____

Dinner yesterday: _____ Late PM Snack foods: _____

Bars/Shakes: _____ Glasses or Ounces of plain water intake/day: _____

Please List Any Dietary Restrictions: _____

What level of change to your living habits are you willing to make to improve your overall well-being? T Whatever It Takes T Significant Change T Some Change T No Change

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Please write down all the medications that you are currently taking at home. Please include any homeopathic/herbals or non prescription medications.

Medication	Dosage/Strength	How Many Times/Day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Pharmacy (name and number):

_____

Compound Pharmacy (name and number):

_____