

Brooke Baggett, L.Ac., MTCM, CBP, PaRama, RMT

745 Distel Drive Ste 206 Los Altos CA 94022-1523 ph. 408.202.3444 www.mosaichealingarts.com

PERSONAL INFORMATION (PLEASE PRINT)

Name	SSN#						
Home Address							
City, ST, Zip/Postal Code							
Primary Phone	Secondary Phone						
Email							
Occupation							
Birth Date	Age						
Gender	<input type="checkbox"/> M	<input type="checkbox"/> F	Marital Status	<input type="checkbox"/> S	<input type="checkbox"/> M	<input type="checkbox"/> D	<input type="checkbox"/> W
Nr of Children							
Family Physician	Phone						
Emergency Contact	Phone						
Who may we thank for referring you to our office?							

24- HOUR CANCELLATION POLICY

Our clients are important to us, and we appreciate the opportunity to serve in your healing process. If however you are unable to keep your appointment, we ask that you provide a minimum of 24-hours notice. As time and space is limited, providing a minimum of 24-hours notice enables us to serve potential clients and compensate for lost revenue. Without a minimum 24-hours notice, the full appointment fee will be charged to you for your missed appointment.

I have read and understand my responsibility for payment of services.

Signature

Date

HEALING ARTS

CLIENT CONSENT FORM

I _____ (**print name**), understand that the intuitive energy healing session provided by the practitioner is intended to enhance relaxation, increase communication within the areas of the body, and to educate me to possible energetic or emotional blocks that may be creating pain, discomfort or disease.

I understand that an intuitive energy healing session is non-invasive, safe and objective. It utilizes the body's own innate intelligence to reestablish communication within itself.

I understand that an intuitive energy healing session is not a substitute for medical care or medications. I am aware that the practitioner does not diagnose illness or disease nor does the practitioner prescribe medications. I understand the practitioner strongly recommends immediate medical attention for any physically based conditions.

I understand that participation in an intuitive energy healing session is voluntary and that at all times I may choose to end our participation. I understand that the safety and care is ultimately my responsibility.

Payment is due at time of service. Since time has been especially reserved for me, I understand the following 24-hour cancellation policy stated below:

24-hour cancellation policy:

Our clients are important to us, and we appreciate the opportunity to serve in your healing process. If however you are unable to keep your appointment, we ask that you provide a minimum of 24-hours notice. As time and space is limited, providing this notice enables us to serve potential clients and compensate for lost revenue. Without a minimum of 24-hours notice, the full appointment fee will be charged to you for your missed appointment.

If I have any questions or concerns, I will address these promptly with the practitioner.

I hereby authorize the practitioner to provide intuitive energy healing sessions.

Signature

Date

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HEALING ARTS

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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 California 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.

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 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 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 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 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, emotional 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 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 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 payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this 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, 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 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 date it is signed (for example, emergency treatment) patient should initial here. _____ Effective as 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.

PATIENT SIGNATURE **X** (Date)

(Or Patient Representative)

(Indicate relationship if signing for patient)

OFFICE SIGNATURE **X** (Date)

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HEALTH HISTORY

This confidential health history packet provides vital information and helps determine the best plan of care for you. Please print clearly and answer each question completely.

Name	Age	Date
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Reason for your visit today:

Check the appropriate box if you have ever experienced any of the following:

- | | |
|----------------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Adverse reaction to medical treatment | <input type="checkbox"/> Kidney disorder |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Musculo-skeletal disorder |
| <input type="checkbox"/> Arthritis or rheumatism | <input type="checkbox"/> Organ transplant |
| <input type="checkbox"/> Artificial heart valves or joints | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Respiratory disorder |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Cancer or tumor | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin disorders |
| <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Special diet |
| <input type="checkbox"/> Eye disorders | <input type="checkbox"/> Stomach or intestinal disorder |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Transfusion (before March 1985) |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hepatitis, Jaundice or Liver disorder | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Urinary tract disorder |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Immune disorder | <input type="checkbox"/> Other _____ |

Is there anything else we should know about your medical history?

Medications & Supplements: Please check the box to indicate what you are currently taking.

- | | | |
|--------------------------------------------------|-----------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Hay fever medication | <input type="checkbox"/> Sleeping pills |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Cold or Flu medications | <input type="checkbox"/> Laxatives | <input type="checkbox"/> Herbs |
| <input type="checkbox"/> Diet pills | <input type="checkbox"/> Oral contraceptives | <input type="checkbox"/> Vitamins |

Please list any medications you are currently taking that are not listed above:

Please list any allergies to medications you have:

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**Habits: Please mark any of the habits listed below which apply to you.
Mark an X for current habits. Mark a ✓ for past habits.**

Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, # of cigarettes / day _____ age started _____
Alcohol use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, # of drinks / week _____ age started _____
Caffeine use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	# of soda/day _____ # coffee/day _____ tea /day _____
Drug use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Type(s) Amount / Age started: _____
Do you exercise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	What type of exercise and how often? _____

**Outlook: How do you feel about the following areas of your life?
Please indicate any problems you are experiencing.**

	Great	Good	Fair	Poor	Bad	Your Comments
Spouse or significant other						
Family						
Diet						
Sex						
Self						
Work						

Major Hospitalizations: If you have ever been hospitalized for any serious medical illness or operation, write in your most recent hospitalizations below.

If you have had more than three such hospitalizations check this box . Do not include pregnancies.

1 st Hospitalization _____	Year _____	operation or illness _____	hospital/city/state _____
2 nd Hospitalization _____	Year _____	operation or illness _____	hospital/city/state _____
3 rd Hospitalization _____	Year _____	operation or illness _____	hospital/city/state _____

Women's Obstetric History: Please fill in completely:

Total # of Pregnancies _____ Living _____ Ectopics _____
Miscarriages _____ Induced Abortions: # and years _____

Current Care:

Are you currently under the care of a Medical Doctor? Yes No

Name of Medical Doctor: _____

Phone of Medical Doctor: _____

Date of Last Physical Exam: _____

Have you ever been treated with acupuncture or Chinese medicine? Yes No

Name of previous Acupuncturist: _____

What other forms of treatment have you sought for your current medical condition? _____

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Please check the appropriate boxes below for any symptoms you have recently experienced.

HEAD & NECK

- Head
- Fainting
- Neck stiffness
- Enlarged lymph glands
- Headaches
- Other

EARS

- Infection
- Pain
- Ringing
- Decreased hearing
- Other

EYES

- Blurred vision
- Visual changes
- Spots
- Eye inflammation
- Other

NOSE, THROAT, & MOUTH

- Bleeding
- Sinus infection
- Hay fever or allergies
- Sore throat
- Difficulty swallowing
- Changes in taste
- Changes in smell
- Oral ulcers
- Other

SKIN

- Hives
- Rashes
- Eczema
- Itching
- Night sweating
- Excessive sweating
- Dryness
- Bruise easily
- Changes in moles or lumps
- Other

RESPIRATORY

- Chronic cough
- Coughing up blood
- Coughing up phlegm
- Difficulty breathing
- Wheezing/asthma
- Frequent colds
- Other

CARDIO VASCULAR

- Palpitations
- Chest pain or tightness
- Rapid heart beat
- Irregular heart beat
- Cold hands/feet
- Swelling of ankles
- Phlebitis
- Other

GASTROINTESTINAL

- Indigestion
- Bloating
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Nausea
- Vomiting
- Vomiting blood
- Blood in stool or black stools
- Hemorrhoids
- Gall bladder disorder
- Recent change in weight
- Food cravings
- Other

NEUROLOGICAL

- Seizures
- Tremors
- Numbness or tingling of limbs
- Paralysis
- Other

MUSCLE & JOINT

- Joint disorder
- Sore or painful muscles
- Weak muscles
- Difficulty walking
- Spinal curvature
- Backache or pain
- Other

UROGENITAL

- Pain/itching of genitalia
- Genital lesions/discharge
- Painful urination
- Frequent urination
- Excessive or scanty urination
- Blood in urine
- Diminished bladder control

Other

FEMALE

- Frequent urinary tract infections
- Frequent vaginal infections
- Pelvic inflammatory disease
- Abnormal Pap smear
- Uterine fibroids
- Irregular periods
- Painful menstrual periods
- Premenstrual Syndrome
- Abnormal bleeding
- Menopausal symptoms
- Breast pain
- Breast lumps
- Nipple discharge
- Other

First day of last menstrual cycle:

Date of last Pap smear:

Are you pregnant? Yes No

Are you nursing? Yes No

Do you use birth control? Yes/Type: No

MALE

- Lumps in testicles
- Prostate problems
- Weak urinary stream
- Impotence
- Other

OTHER

- Insomnia
- Frequent dreams/nightmares
- Anxiety
- Irritability
- Forgetfulness
- Depression
- Fatigue
- Decreased libido
- Feel hot or cold
- Aversion to heat or cold
- Fever and or chills
- Thirst
- Psychiatric treatment
- Other

Please list any other symptoms not covered above: