SPARK ACUPUNCTURE
410 S. Melrose Dr Suite 200
Vista, Ca 92081
760.630.8060

Consent to Acupuncture Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substance from the Oriental Materia Medica by **Seonghyeon "Shawn" Park, L.Ac.**

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat the bodily dysfunction or disease, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunctions or disease, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include but are not limited to: changes in bowel movements, abdominal pain/discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the practitioner as soon as possible.*

Cupping/Acupressure/Tui-Na: I understand that I may also be given cupping/acupressure/tui-na as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered in the treatment. I am aware that certain adverse effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for more detailed explanation. I give my permission and consent to treatment.

______________________________	____________________
Signature of Patient/Patient Representative	Today's Date
______________________________	____________________
Print Name	Relationship to Patient

SPARK ACUPUNCTURE

410 S. Melrose Dr Suite 200

Vista, CA 92081

760.630.8060

PATIENT INFORMATION

First Name ______________________ Last Name __________________________ Middle Initial ___ Sex (M / F)

Address ____
(number) (street) (city) (state) (zip code)

Social Security# _____-_____-_____ Birth Date ___ / ___ / _____ Age _____ Height _______ Weight _______

Phone # (____) _____ - _________ Cell # (____) _____ - ________Email ____________________________

Married ( ) Single ( ) Other ( ) ____________ Spouse's Name ______________________________

Occupation ____________________ Employer ________________ Work Address____________________

IN CASE OF AN EMERGENCY, CONTACT____
Name Relationship Phone #

How did you hear about us? ___________________________ Is this your first time getting acupuncture? Y / N

Primary Care Practitioner ____________________________________ Phone __________________

MEDICAL HISTORY

Successful health care and preventative care are only possible when the practitioner has a complete understanding of the patient's physical, mental, and emotional state. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank You.

Please list any allergies/hypersensitivities ____

____

Please list any medications and/or supplements you are currently taking, including the associated condition(s) __________

____

____

Please list any surgeries or major injuries, including dates ____

____

____

Are you pregnant? Y / N If yes, how many weeks ______

Do you have a pacemaker or any metal devices in your body? Y / N

NAME: ______________________

1. What is your **worst** complaint? ______________________

When and How did your condition begin? ______________________

Rate your pain/discomfort on the scale. (circle) (none) = **0 1 2 3 4 5 6 7 8 9 10** = (severe)

How often do you experience this complaint? (circle) Occasionally (0-25% of the day) Intermittently (26-50% of the day) Frequently (51-75% of the day) Constantly (76-100% of the day)

How are your symptoms changing? (circle) **Improving** **Not Changing** **Worsening**

2. What is your **second worst** complaint? ______________________

When and How did your condition begin? ______________________

Rate your pain/discomfort on the scale. (circle) (none) = **0 1 2 3 4 5 6 7 8 9 10** = (severe)

How often do you experience this complaint? (circle) Occasionally (0-25% of the day) Intermittently (26-50% of the day) Frequently (51-75% of the day) Constantly (76-100% of the day)

How are your symptoms changing? (circle) **Improving** **Not Changing** **Worsening**

3. Briefly describe any other complaints: ______________________

____

What aggravates your symptom(s)? ______________________

What alleviates your symptom(s)? ______________________

Have you sought other therapies or treatments for the stated condition(s)? Y / N List ______________________

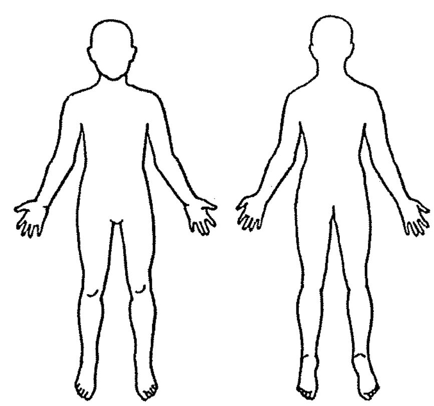
Are you experiencing pain/discomfort in any area of your body? Y / N If YES, use the illustration below to mark areas of pain/distress.

Circle any other symptoms you are experiencing.

(Sharp Pain) (Dull Ache) (Shooting Pain)
(Burning Pain) (Throbbing Pain) (Popping) (Weakness)

6. Please indicate on the diagram to the right where you experience your symptoms. (Use the key below)

Pain XXX Numbness OOO Tingling √√√
Stiffness / / / Burning + + +



What would you most like to achieve with acupuncture treatments? ______________________

____

____

OFFICE POLICIES / PROCEDURES AGREEMENT AND CUSTOMARY FEE SCHEDULE

FINANCIAL ARRANGEMENTS

I understand and agree that health and accident policies are an arrangement between an insurance company carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

INSURANCE BILLING/PAYMENT

Patients are ultimately fully responsible for services provided by our office. For your convenience, our office will make an effort to verify your insurance benefits. However, please note that verification of benefits is not guaranteed. Your insurance company makes the final determination of insurance benefits when they consider the claim. Patients are fully responsible for payment of services not authorized or covered by their insurance company. Patients that are represented by an attorney in PI cases must notify our office the same day if changing or canceling representation.

PAYMENT ARRANGEMENTS

We understand that occasions arise when it may be necessary for you to request to be billed rather than pay at the time of service. This may include setting up a payment plan for those who may require extensive treatments. Payment is due within 30 days of the service rendered. If there are legitimate financial problems, please discuss them with our office manager prior to the 30 days so that we may find a workable solution. If an account is not paid within 30 days and no payment arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You will also be charged a monthly interest of 10% based off your principal balance until all fees are paid.

APPOINTMENT SCHEDULING

Canceling or rescheduling appointments requires a 24 hour notice otherwise you will be charged a fee for the missed scheduled service.

NOTICE OF PRIVACY POLICY

We are required by law to make sure your medical information is protected; give you notice describing our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect. By signing below you are acknowledging that you have received our Notice of Privacy Policy.

NOTICE OF PRIVATE PRACTICES/ BUSINESSES AND PATIENT'S FREEDOM OF CHOICE

There are separate practices/ businesses within this office. Each entity is owned and operated as separate businesses and may have separate fee schedules and different treatment techniques. I understand that each service offered at this facility are owned and operated as separate businesses and hold each business harmless from any act or omission which may occur by any of the other businesses during the course of my treatment at this facility. Circumstances may arise such as emergencies, or doctor vacation or sick leave and you may request to be treated by another doctor within this office. If you are treated by another doctor you may be charged a different fee. Patients are free to choose any doctor or organization that may be recommended by our doctors. You do not have to use the facilities at our office for treatments and we can assist you on finding an alternative locations or sources.

CONSENT TO TREAT MINOR

I, ______________________________ the parent or legal guardian, who has permission to make decisions for ______________________________, a minor child, authorize any necessary treatment at Spark Acupuncture for my minor child and fully agree to the above terms.

Printed Name of Patient	Patient's Signature or that of Legal Representative
Today's Date	If Legal Representative, Indicate Relationship

SPARK ACUPUNCTURE

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:______________________________ **Date of Birth:**________________________

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of **Spark Acupuncture.**

I understand that the Notice describes the uses and disclosures of my protected health information by **Spark Acupuncture** and informs me of my rights with respect to my protected health information.

Patient's Signature or that of Legal Representative	*Printed Name of Patient or that of Legal Representative*
Today's Date	*If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):____

Employee Name	*Today's 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 California 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 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, 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 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. 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) 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 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.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

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 you are 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.

PATIENT NAME:

ACUPUNCTURIST NAME: Seonghyeon Park L.Ac.

PATIENT SIGNATURE **X** (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

ACCIDENT / INJURY QUESTIONS

Patient: ______________________________ **Date:** ____________

Date of Accident: ___ / ___ / ____ **Time of Accident:** ___: ____ **AM / PM** **Place** **(City/State):** ____________

What was the cause of your Accident / Injury? **(Circle)** **Automobile Accident** **Work Injury** **Slip/Fall**

Describe in your own words what happened: ____

____

____

How did you feel immediately after the accident? (eg. Confused, dazed, dizzy, nervous, scared, nausea, etc…)

____

Where did you immediately develop pain following the accident? ____________________

____

Are there additional symptoms that developed hours, days or weeks after the accident? (eg. Headaches, tingling…)

____

EMERGENCY CARE

Did you receive any medical care at the scene of the accident? (eg. Paramedics) **(YES / NO)**

Have you been to the hospital for this accident? **(YES / NO)** If yes, what hospital? ____________Date: ______

Were you taken to the hospital by ambulance? **(YES / NO)** Other: ____________________

Please list the areas of your body where **(X-Rays / CT / MRI)** were taken: ____________________

Have you been prescribed any medications for this accident? **(YES / NO)** List: ____________________

List ***any other Doctors' names and specialties with appointment dates*** you have seen for this accident?

____

AUTOMOBILE ACCIDENT

What ***year and type*** of automobile were you driving? ______________Your approximate speed: ____ MPH

What parts of your vehicle were struck during the collision? ____________________

If struck by another vehicle, what type of vehicle was it? ______________Approximate speed: ____ MPH

What was the total damage estimate of your vehicle? **$**__________ Vehicle Totaled: **(YES / NO)**

Did the police arrive at the scene and was a report of the accident taken? **(YES / NO)**

Were you wearing your seatbelt? **(YES / NO)** Did the airbags deploy? **(YES / NO)**

Did you strike your head? **(YES / NO)** If yes, circle what your head hit: **Headrest, Airbag, Steering Wheel, Window, Other**

Did you strike any other body part? (eg. Knees against dashboard, etc…) **(YES / NO)** ____________________

Did you expect the vehicle was going to hit you? **(YES / NO)** Were you able to brace yourself? **(YES / NO)**

Was your head turned **(Right or Left)**, or looking **(Up or Down)** at the time of the impact? ____________

Did you lose consciousness? **(YES / NO)** If yes, how long would you estimate you were out? ____________

Patient Signature: ______________________ **Doctor Signature:** ____________

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name ______________________________ Date ____________________

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

____
Examiner

OTHER COMMENTS: ____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name ______________________________ Date ________________

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

   No pain — Worst pain possible

   0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

   No interference — Unable to carry out activity

   0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

   No interference — Unable to carry out activity

   0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

   Not at all anxious — Extremely anxious

   0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

   Not at all depressed — Extremely depressed

   0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

   Have made it no worse — Have made it much worse

   0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

   Completely control it — No control whatsoever

   0 1 2 3 4 5 6 7 8 9 10

____
Examiner

OTHER COMMENTS: ______________________________

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients *JMPT* 2002; 25 (3): 141-148.

HEADACHE DISABILITY INDEX

Patient Name ______________________________ Date ________________

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week
2. My headache is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO		
____	____	____	E1.	Because of my headaches I feel handicapped.
____	____	____	F2.	Because of my headaches I feel restricted in performing my routine daily activities.
____	____	____	E3.	No one understands the effect my headaches have on my life.
____	____	____	F4.	I restrict my recreational activities (eg, sports, hobbies) because of my headaches.
____	____	____	E5.	My headaches make me angry.
____	____	____	E6.	Sometimes I feel that I am going to lose control because of my headaches.
____	____	____	F7.	Because of my headaches I am less likely to socialize.
____	____	____	E8.	My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.
____	____	____	E9.	My headaches are so bad that I feel that I am going to go insane.
____	____	____	E10.	My outlook on the world is affected by my headaches.
____	____	____	E11.	I am afraid to go outside when I feel that a headaches is starting.
____	____	____	E12.	I feel desperate because of my headaches.
____	____	____	F13.	I am concerned that I am paying penalties at work or at home because of my headaches.
____	____	____	E14.	My headaches place stress on my relationships with family or friends.
____	____	____	F15.	I avoid being around people when I have a headache.
____	____	____	F16.	I believe my headaches are making it difficult for me to achieve my goals in life.
____	____	____	F17.	I am unable to think clearly because of my headaches.
____	____	____	F18.	I get tense (eg, muscle tension) because of my headaches.
____	____	____	F19.	I do not enjoy social gatherings because of my headaches.
____	____	____	E20.	I feel irritable because of my headaches.
____	____	____	F21.	I avoid traveling because of my headaches.
____	____	____	E22.	My headaches make me feel confused.
____	____	____	E23.	My headaches make me feel frustrated.
____	____	____	F24.	I find it difficult to read because of my headaches.
____	____	____	F25.	I find it difficult to focus my attention away from my headaches and on other things.

OTHER COMMENTS:____

____
Examiner

With permission from: Jacobson GP, Ramadan NM, et al. *The Henry Ford Hospital headache disability inventory (HDI)*. Neurology 1994;44:837-842.

LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention.

Please Circle an Answer for Each Activity

TODAY, do you or would you have any difficulty at all with:

	ACTIVITIES	Unable to Perform Activity	Severe Difficulty	Moderate Difficulty	Mild Difficulty	No Difficulty
1	Any of your usual work, housework, school activities	4	3	2	1	0
2	Your usual hobbies, recreational or sporting activities	4	3	2	1	0
3	Getting into or out of the bath	4	3	2	1	0
4	Walking between rooms	4	3	2	1	0
5	Putting on your shoes or socks	4	3	2	1	0
6	Squatting	4	3	2	1	0
7	Lifting an object, like a bag of groceries from the floor	4	3	2	1	0
8	Performing light activities around your home	4	3	2	1	0
9	Performing heavy activities around your home	4	3	2	1	0
10	Getting into or out of a car	4	3	2	1	0
11	Walking 2 blocks	4	3	2	1	0
12	Walking a mile	4	3	2	1	0
13	Going up or down 10 stairs (about 1 flight of stairs)	4	3	2	1	0
14	Standing for 1 hour	4	3	2	1	0
15	Sitting for 1 hour	4	3	2	1	0
16	Running on even ground	4	3	2	1	0
17	Running on uneven ground	4	3	2	1	0
18	Making sharp turns while running fast	4	3	2	1	0
19	Hopping	4	3	2	1	0
20	Rolling over in bed	4	3	2	1	0
	Column Totals:					

SCORE: __________/80 = __________

NAME: ______________________________ **DATE:** ______________

FOR CLINICIAN: Lower Extremity Functional Scale Measurement Properties
LEFS is scored via summation of all responses (one answer per section) and compared to a total possible score of 80
Error +/- 5 points: an observed score is within 5 points of patients "true" score
Minimum detectable change (MDC); 9 points; change of more than 9 points on the LEFS represents a true change
Minimum clinically important difference (MCID): 9 points; Clinicians can be reasonably confident that a change of greater than 9 points is..a clinically meaningful functional change.

Upper Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your upper limb problem for which you are currently seeking attention. Please check (√) an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

Activities	Extreme Difficulty Or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
Any of your usual work, household, or school activities					
Your usual hobbies, recreational or sporting activities					
Lifting a bag of groceries to waist level					
Lifting a bag of groceries above your head					
Grooming your hair					
Pushing up on your hands (e.g., from bathtub or chair)					
Preparing food (e.g., peeling, cutting)					
Driving					
Vacuuming, sweeping, or raking					
Dressing					
Doing up buttons					
Using tools or appliances					
Opening doors					
Cleaning					
Tying or lacing shoes					
Sleeping					
Laundering clothes (e.g., washing, ironing, folding)					
Opening a jar					
Throwing a ball					
Carrying a small suitcase with your affected limb)					

Stratford P, Binkley JM, Stratford POW. Development and initial validation of the upper extremity functional index. Physiotherapy Canada Fall 2001;259-266, 281.

Patient name: ______________________ Signature: ______________________ Date: ____________

Score ______________/80 MDC (minimum detectable change) = 9 pts Error +/- 5 scale points

ADL (ACTIVITIES OF DAILY LIVING & FUNCTIONAL ASSESSMENT)

Patient Name: ____________________________ **Date of Injury:** _____________ **Date:** ______________

Instructions: Please check the activities that currently bother you. Only check one box from each column.

ACTIVITY	ANNOYS ME ONLY	SLOWS ME DOWN	HARD TO PERFORM	UNABLE TO PERFORM
Bending head and neck				
Turning head and neck				
Bending waist – lower back				
Twisting waist – lower back				
Sitting				
Standing				
Walking				
Driving a car				
Riding a bicycle				
Reaching hands over head or shoulder level				
Household chores / cleaning / vacuuming etc.				
Combing / Brushing hair / Bathing				
Typing on a keyboard / Using home computer				
Carrying objects in hand				
Gripping objects or using wrists or hands				
Sleeping / Lying in bed				
Recreational or hobby activities				
Running or jogging				
Sports activities				
Yard work / Gardening etc.				
Using cell phone or tablet				
Crouching or squatting				
Kneeling				
Pushing or pulling with arms /hands				
Reading or Writing				
Dressing myself				
Playing with my children				
Going up or down stairs				
I have pain sitting and doing nothing				
Participating in sexual activity				
SCORE 30 Total Choices				
	(0-25%)	**(26-50%)**	**(51-75%)**	**(76-100%)**

Patient Signature: ____________________________

Office Notes: ADL Total ____ **/ 30** ____

____

____ **Doctor Signature:** ____________________

Symptoms

Patient ______________________ Date ___________ Date of Injury ___________

Please fill in all symptoms you currently have <u>that you did not have</u> before the accident.

<u>Orthopedic & Musculoskeletal Symptoms</u>

- ☐ "Clunk" sound with neck movements
- ☐ Neck pain
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Shoulder pain ☐ Left ☐ Right
- ☐ Upper arm pain ☐ Left ☐ Right
- ☐ Elbow pain ☐ Left ☐ Right
- ☐ Forearm pain ☐ Left ☐ Right
- ☐ Wrist pain ☐ Left ☐ Right
- ☐ Hand pain ☐ Left ☐ Right
- ☐ Hip pain ☐ Left ☐ Right
- ☐ Upper leg pain ☐ Left ☐ Right
- ☐ Knee pain ☐ Left ☐ Right
- ☐ Lower leg pain ☐ Left ☐ Right
- ☐ Ankle pain ☐ Left ☐ Right
- ☐ Foot pain ☐ Left ☐ Right
- ☐ Jaw pain
- ☐ Clicking in Jaw
- ☐ Pain when chewing
- ☐ Face pain
- ☐ Chest pain
- ☐ Stomach pain
- ☐ Bruise to ______________
- ☐ Scrape/Cut to ______________
- ☐ Other Symptom ______________
- ☐ Other Symptom ______________

<u>Neurological Symptoms</u>

- ☐ Numb/Tingling Arm / Hand L R
- ☐ Numb/Tingling Leg / Foot L R
- ☐ Weakness Arm / Hand L R
- ☐ Weakness Leg / Foot L R

<u>Symptoms Associated with Injuries</u>

- ☐ Stiffness or limited movement in joint(s)
- ☐ Headaches
- ☐ Muscle spasms/sore muscles
- ☐ Dizziness, lightheaded, woozy feeling
- ☐ Visual disturbances or vision change
- ☐ Sleep changes/disruption of patterns
- ☐ Pain radiates from one place to another
- ☐ Anxiety or nervous when driving
- ☐ Irregular Heartbeat or uneven pulse
- ☐ Feeling depressed about things
- ☐ I am taking the following medications _____

____

<u>Brain/Neuropsych/MTBI/PTSD Symptoms</u>

- ☐ I prefer being alone now (not socializing)
- ☐ I am sleepy, tired during day or doze off easily
- ☐ Upset stomach, nausea, heartburn or vomiting
- ☐ Difficulty concentrating, mind wanders easily
- ☐ I get overwhelmed easily
- ☐ Mood swings, happy one moment then sad
- ☐ Agitation (can't sit still, need to move around)
- ☐ Sadness, tearful episodes, crying easily
- ☐ Blurry vision, had to get or change glasses
- ☐ Asking people to repeat things or hearing problem
- ☐ I make wrong turns driving or can't remember time
- ☐ I get confused easily or cannot multi-task anymore
- ☐ I have difficulty finding some words when talking
- ☐ Bright lights bother me
- ☐ I cannot pay attention as long as before
- ☐ I am eating more or less than normal
- ☐ Room spins, lightheaded or woozy feeling
- ☐ Balance problems
- ☐ I feel like my head is "Foggy"
- ☐ I have forgotten computer passwords or ATM PIN
- ☐ I have to re-read things to understand what I read
- ☐ My thinking is slowed down
- ☐ Difficulty with adding/subtracting numbers
- ☐ Fear I will never be the same again
- ☐ Difficulty learning new things
- ☐ Difficulty understanding what people say to me
- ☐ Difficulty remembering or memory problems
- ☐ Cannot take on any more responsibility
- ☐ I can't make decisions as quickly as before
- ☐ Loss of libido or lack of sexual desire
- ☐ I do not feel as confident of my abilities
- ☐ I get panic attacks, fast heartbeat, nervous
- ☐ I am more irritable than usual
- ☐ Some food or drink tastes "Funny" to me now
- ☐ I get frustrated very easily
- ☐ Difficulty planning my life or organizing my work
- ☐ Flashbacks or frightening thoughts about accident
- ☐ I have had bad dreams about the accident
- ☐ I avoid places & objects that remind me about it
- ☐ I feel emotionally numb-no interest in my hobbies
- ☐ I'm feeling strong guilt, worry or depression
- ☐ I am having trouble remembering the accident
- ☐ I am easily startled since the accident - "jumpy"
- ☐ I feel tense or "on edge" most of the time
- ☐ I am having difficulty sleeping
- ☐ I get angry easily or even yell at people now

SPARK ACUPUNCTURE
410 S. Melrose Dr Suite 200
Vista, CA 92081
Office: 760.630.8060 // Fax: 760.630.8060

NOTICE OF DOCTOR LIEN ON PERSONAL INJURY PROCEEDS

I hereby authorize **Seonghyeon "Shawn" Park, L.Ac.** to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc. of me in regard to the accident on or about __________________________, for which you have been retained.

I understand that all bills incurred by me at **Seonghyeon "Shawn" Park, L.Ac. 's** office are my responsibility to pay and I will either pay them in full at the time of service or make payment arrangements with **Seonghyeon "Shawn" Park, L.Ac.** I also understand that, unlike my attorney, **Seonghyeon "Shawn" Park, L.Ac.** does not work on a contingency fee and I must pay for her services at the time of his rendering of them and that this lien is only to protect her interests in case there is a balance owing when my case is resolved.

I irrevocably instruct my attorney to withhold from my settlement or judgment any amount that, at that time, is owed **Seonghyeon "Shawn" Park, L.Ac.** for my healthcare in connection with this accident and pay it directly and promptly to **Seonghyeon "Shawn" Park, L.Ac.** at:

SPARK ACUPUNCTURE
Seonghyeon "Shawn" Park, L.Ac.
410 S. Melrose Dr Suite 200
Vista, CA 92081

I am granting **Seonghyeon "Shawn" Park, L.Ac.** an irrevocable lien on the proceeds of my legal case and it is my intent that this lien shall be binding on my present attorney and/or any subsequent attorney which either I might hire or to whom my present attorney may assign this case. In the event I have no attorney, I hereby instruct any insurance company from which I may receive a settlement in regard to this accident to add **Seonghyeon "Shawn" Park, L.Ac.** as a payee on the settlement draft.

Print Name	Patient's Signature	Date

I, the attorney of record for the above-named signatory in regard to the accident in question, hereby agree to abide by the terms of this lien.

Attorney (Please Print)	Attorney's Signature	Date

SPARK ACUPUNTURE
410 S. Melrose Suite 200
Vista, CA 92081
Office: 760.630.8060 // Fax: 760.630.8060

Auto Insurance Information

Patient Name: ________________________________

Date of Birth: ________________________________

Your Auto Insurance Company

Name of Insurance Company: ________________________________
Name of Insured: ________________________________
Claim Number: ________________________________
Insurance Adjuster's Name: ________________________________
Insurance Adjuster's Phone Number: ________________________________

Third Party Insurance Company (other driver)

Name of Insurance Company: ________________________________
Name of Insured: ________________________________
Claim Number: ________________________________
Insurance Adjuster's Name: ________________________________
Insurance Adjuster's Phone Number: ________________________________

Attorney Information

Name of Attorney: ________________________________
Phone Number: ________________________________
Fax: ________________________________

AUTHORIZATION FOR RELEASE OF RECORDS FROM:

____

____

____

____

____

I HEREBY REQUEST AND AUTHORIZE THE RELEASE OF RECORDS TO:

SPARK ACUPUNCTURE
410 S Melrose Dr. Ste 200
Vista, CA 92081
Ph: 760-630-8060 / Fax: 760-630-8060

☐ ALL RECORDS

☐ HEALTH RECORDS DATE(S):____________ TO ____________

☐ X-RAY, MRI, CT REPORTS

☐ OTHER: ____

PATIENT'S NAME: ____

PATIENT'S SIGNATURE: ____________________________________

PATIENT'S DATE OF BIRTH: ________________________________

DOCTOR'S SIGNATURE: ____________________________________