TRIUNE
WELLNESS CENTER

I'm very grateful our paths have crossed and that we will be meeting together very soon. I am excited to get to know you, what your health issues are and to help you start healing. In the mean time before we meet, some paperwork will be needed. This will ensure that I have the best overall picture of how to help you. In this file you will find the paperwork and everything that you will need to make the most of your initial appointment.

Please fill this paperwork out completely and sign where appropriate (last 2 pages). Bring the paperwork with you to the session completely filled out. If this is not done, 20-30 minutes of the session will be lost and no additional time will be added. If we are having a phone consultation, please fill out, scan and return to me through email the night before our first session (dr@drscottgraves.com).

Initial 1st appointment (55 minutes - $145):

- We will go over a thorough and detailed health history (20-30 minutes). Even though you fill out paperwork, more questions may be asked for further clarification into your specific issues.
- We also will do treatment (acupuncture normally) if the appointment is done in the clinic.
- Intuitive testing (applied kinesiology), tongue diagnosis and pulse diagnosis. Using the Nutrition Response Testing format through the pulse, you will be tested for the weakest organs, glands or parts of the body that need the most physical healing and what organic whole food supplements can help those parts of the body to best heal. You body is also tested for heavy metals, chemicals, food sensitivities, pathogens or scars that may be causing confusion in your nervous system. If a full detoxification is needed, it may be suggested. Supplements are always recommended and those are an additional cost, usually between 80-$120.
- This cost of the initial appointment also includes full access to Dr. Scott's incredible online course called Total Gut Transformation ($100 value). If it is a distance session being done over the phone, payment can be made by credit card. Payment is made in full at the end of the 1st appointment with cash, check or credit card.

Follow up appointments (55 minutes - $100)

- We will go over a detailed report discussing what was found in the testing (20-30 minutes). The focus of this report is mostly on physical healing. You are encouraged to ask questions. Other resources will be presented here that will greatly aid you in the healing process.
- Healthy clean eating. Many people have questions about what to eat and what is best for them. Dr. Scott will give some general recommendations about how to eat in order to heal.
- Acupuncture treatment will be performed. In phone consultations on the 2nd visit, we generally tend to jump right into emotional release.
- Express acupuncture visits (30 minutes - $60) are available for those that need to be seen more than once per week. Usually this is for those with acute injuries.

*There is a 24 hour rescheduling/cancellation policy. You are encouraged to put in a 48 hour (2 day) reminder in your phone so that you can have adequate time to reschedule or cancel. Rescheduling or canceling that is done within 24 hours will be subject to the full cost of an hour long session ($95).

Chinese medicine is a complete system of medicine and my mission is to bring the brilliance of this medicine to the world and to help as many people as possible by natural means. Any and all health problems can be treated with Chinese medicine including headaches, asthma, depression/anxiety, digestive issues, pain, PMS symptoms, infertility, fatigue, insomnia, skin issues (acne, eczema, dermatitis), or anything else.

Health And Well Being History Form

Name:	Email:
Address:	City, State, Zip:
Home Phone:	Profession:
Cellular Phone:	Referred by:
Date:	Date of Birth:

PART 1.

* Please answer the following questions honestly and to the best of your ability.

TRIUNE WELLNESS CENTER

Describe the problem(s) for which you seek help. Please include dates when each problem occurred:

Past medical history (previous injuries, accidents, surgeries, etc. Please describe and include approximate dates:

List the medications (including over the counter) and supplements you are currently taking:

Have you ever had this problem before, and if so when?

What are your goals in us working together?

Please list any other kind of healthcare professional you are seeing for this/these problem(s):

Please list any medical tests you have had within the past year:

PART 2.

* Please mark the circle that best describes the frequency you experience the below conditions. **Leave blank if there is never a problem.**

1 Rarely (once a month or less)
2 Occasionally (less than once a week)
3 Frequently (more than once a week)
4 Constantly

DIGESTION

1 2 3 4 Loose stool or Diarrhea	1 2 3 4 Gas or belching	1 2 3 4 Blood in stool
1 2 3 4 Constipation	1 2 3 4 Stomach or intestinal pain	1 2 3 4 Black or dark stool
1 2 3 4 Poor digestion	1 2 3 4 Heartburn	1 2 3 4 Light colored stool
1 2 3 4 Parasites	1 2 3 4 Excessive appetite	1 2 3 4 Difficulty digesting oily food
1 2 3 4 Acid reflux	1 2 3 4 Poor appetite	yes no High cholesterol
1 2 3 4 Hiatal Hernia	1 2 3 4 Irritable bowels	yes no Gall stones
1 2 3 4 Nausea / vomiting	1 2 3 4 Hemorrohoids	

RESPIRATORY

1 2 3 4 Wet cough	1 2 3 4 Nasal problems	1 2 3 4 Other:_____
1 2 3 4 Dry cough	1 2 3 4 Poor sense of smell	yes no Pneumonia
1 2 3 4 Chest tightness	1 2 3 4 Sinus problems	yes no Asthma
1 2 3 4 Shortness of breath	1 2 3 4 Allergies	yes no Emphysema
1 2 3 4 Congestion	1 2 3 4 Hay fever	yes no Bronchitis
1 2 3 4 Wheezing	1 2 3 4 Catches colds easily	yes no Do you smoke? Number per day:_____

CARDIOVASCULAR

1 2 3 4 Hypertension	1 2 3 4 Restlessness	yes no Heart disease
1 2 3 4 Hypotension	1 2 3 4 Heart palpitation	yes no Phlebitis
1 2 3 4 Chest pain	1 2 3 4 Slow heart rate	1 2 3 4 Poor blood clotting
1 2 3 4 Dizziness	1 2 3 4 Poor circulation	yes no Heart attack How many times? ____
1 2 3 4 Easily bruised	1 2 3 4 Blood clots	yes no Stroke How many times? ____
1 2 3 4 Edema	1 2 3 4 Sweaty hands / feet	yes no Other:_____
1 2 3 4 Cold hands / feet	1 2 3 4 Anemia	

URINARY

1 2 3 4 Painful urination	1 2 3 4 Ear aches	yes no Low back pain
1 2 3 4 Incontinence	yes no Hearing impairment	yes no Knee problems
1 2 3 4 Difficulty with urination	yes no Kidney stones	yes no Other:_____
1 2 3 4 Ringing in ears	yes no Kidney infections	

NERVOUSSYSTEM

yes no Dyslexia	yes no Epilepsy	yes no Developmental or growth problems
yes no Learning disorder	yes no Head injury	yes no Nervous disorder? Type:_____
yes no Multiple Sclerosis	yes no Numbness, Where?_____	yes no History of mold exposure
yes no Muscular dystrophy	yes no Tingling, Where?_____	yes no Past mononucleosis infection

MUSCLES / JOINTS

1 2 3 4 TMJ pain	1 2 3 4 Arm Weakness	yes no Rheumatoid Arthritis
1 2 3 4 Facial pain	1 2 3 4 Trunk Weakness	yes no Artificial joints
1 2 3 4 Loss of Balance	1 2 3 4 Difficulty walking	yes no Broken bones, fractures?_____
1 2 3 4 Poor coordination	1 2 3 4 Joint swelling	_____
1 2 3 4 Leg Weakness	yes no Osteoarthritis	yes no Pins, etc?_____

MUSCLES / JOINTS (cont)

Mark the circle of painful areas, and indicate on which side : (R) right and / or (L) left

yes	no	Shoulder	R L	yes	no	Legs	R L	yes	no	Mid back	R L
yes	no	Arm	R L	yes	no	Knee	R L	yes	no	Low back	R L
yes	no	Elbow	R L	yes	no	Foot	R L	yes	no	Limited movement? Where? _____	
yes	no	Hands	R L	yes	no	Neck	R L				
yes	no	Hip	R L	yes	no	Upper back	R L				

OTHER

1 2 3 4	Insomnia	1 2 3 4	Fatigue	yes	no	Weight loss
1 2 3 4	Depression	1 2 3 4	Difficulty with speech	yes	no	Tuberculosis
1 2 3 4	Sleep too much, how long? _____	1 2 3 4	No thirst	yes	no	Thyroid problems
1 2 3 4	Shaky	1 2 3 4	Excessive thirst	yes	no	Fibromyalgia
1 2 3 4	Poor memory	1 2 3 4	Dry mouth	yes	no	Poor sense of smell
1 2 3 4	Difficulty paying attention	1 2 3 4	Pain at night	yes	no	Poor sense of taste
1 2 3 4	Anxiety	1 2 3 4	Headaches	yes	no	Cancer, Where? _____
1 2 3 4	Easily angered	1 2 3 4	Migraines	yes	no	Allergies? List: _____
1 2 3 4	Obsessive tendencies in work relationships	1 2 3 4	Eye pain			
1 2 3 4	Difficulty making plans or decisions	1 2 3 4	Dry eyes	yes	no	Hepatitis? type: ____
1 2 3 4	Dizziness	1 2 3 4	Watery eyes	yes	no	Infectious disease: _____
1 2 3 4	Soft or brittle nails	1 2 3 4	Other eye problems? _____	yes	no	Herpes
1 2 3 4	Intolerance to temperature / weather changes	yes	no Dental problems	yes	no	Candida
1 2 3 4	Fever	yes	no Poor hearing	yes	no	Shingles
1 2 3 4	Chills	yes	no Difficulty swallowing	yes	no	Chemical dependency _____
1 2 3 4	Nose bleeds	yes	no Diabetes			
1 2 3 4	Swollen glands	yes	no Weight gain	yes	no	Skin condition: _____

MEN ONLY

1 2 3 4	Prostate problems	1 2 3 4	Impotence	yes	no	Infertility
1 2 3 4	Pain associated with genitals	1 2 3 4	Problems urinating	yes	no	Prostate cancer

WOMEN ONLY

1 2 3 4	Breast pain or tenderness	yes	no Menopausal symptoms: _____	yes	no	Ovarian cysts
yes	no Breast lumps	yes	no Are your cycles regular? Length of cycle: _____	yes	no	Endometriosis
yes	no Nipple discharge	yes	no Painful menses with heavy or excessive flow	yes	no	PMS
yes	no Menopause	yes	no Painful intercourse	yes	no	Infertility

WELL BEING

* Please circle any of the following feelings you have experienced in the last few months .

Abused	Paranoid	Unable to grieve	Panic
Criticized	Overwhelmed	Apprehensive	Intolerant
Overworked	Muddled	Agitated	Uncertainty
Paralyzed	Persecuted	Uneasy	Aggravated
Depressed	Guilty	Distress	Annoyed
Rejected	Easily irritated	Fearful	Angry
Despair	Anxious	Impatient	Outraged
Helpless	Sad	Intimidated	Nervous
Hopeless	Grieving	Restless	Worried

* Please mark the circle that best describes the level of stress for the below listings .

My family stress is:	None	Minimal	Moderate	Severe
My relationship stress is:	None	Minimal	Moderate	Severe
My work stress is:	None	Minimal	Moderate	Severe
My financial stress is:	None	Minimal	Moderate	Severe
My health stress is:	None	Minimal	Moderate	Severe
Other stress is _____:	None	Minimal	Moderate	Severe

How much time do you have for yourself to relax and what do you do to relax, ie. hobbies, meditation, etc ?
Do you exercise? And if so, what kind and how often?
How many hours a night do you sleep? _____ Is your sleep restful? _____If not, please explain:_____

PART 3.

* Please list areas of pain and mark the circle that best describe the level of discomfort on a scale of 1 to 10 .

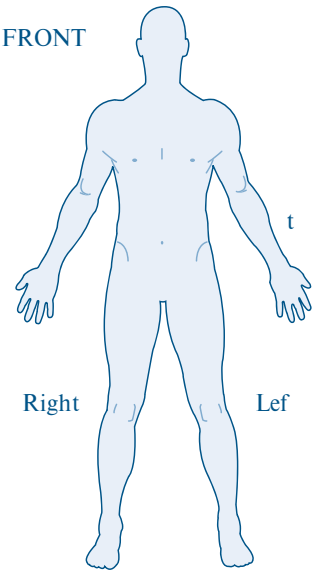
1. Slight awareness of discomfort.
2-3. Awareness o f discomfort as an aggravation.
4-6. Pain is strong but you are still functional.
7-9. Pain is so strong you are unable to function normally.
10. You feel like you need to go to the emergency room.

1 2 3 4 5 6 ● 8 9 10 example: **neck**	1 2 3 4 5 6 7 8 9 10
1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10

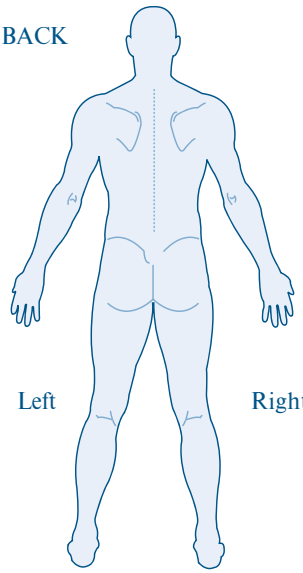
PART 4.

* Please shade areas of pain or discomfort on the body diagrams and make comments on the side if necessary.

FRONT



BACK



COMMENTS:

Daily Record of Food Intake | Your diet may be the key to better health.

Please record what you have consumed/eaten for the previous 2 days. Please be sure to include the approximate amount of each item.

Name: _____

Day 1 - Date:

BREAKFAST *Time:*	**LUNCH** *Time:*	**DINNER** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. 02):		
Other Drinks:		
MID-MORNING SNACK *Time:*	**MID-DAY SNACK** *Time:*	**NIGHTTIME SNACK** *Time:*
Snack:		
Bowel Movements *(#andconsistency):*	**Hours of Sleep:**	**Quality of Sleep** (good) 1 2 3 4 5 (poor)

Day 2 - Date:

BREAKFAST *Time:*	**LUNCH** *Time:*	**DINNER** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. 02):		
Other Drinks:		
MID-MORNING SNACK *Time:*	**MID-DAY SNACK** *Time:*	**NIGHTTIME SNACK** *Time:*
Snack:		
Bowel Movements *(#andconsistency):*	**Hours of Sleep:**	**Quality of Sleep** (good) 1 2 3 4 5 (poor)

1. How many servings (cups) of vegetables do you eat per day? _____
2. How many servings (cups) of fruits do you eat per day? _____
3. Where is your cell phone located when you sleep at night? _____
4. Do you use non-organic personal care products? _____
5. How often do you use a microwave? _____
6. Do you have a water filtration system at home? _____ If not, where do you get your drinking water from? _____
7. Do you smoke (cigarettes, marijuana or other)? _____
8. How often do you drink alcohol? _____

ARBITRATION AGREEMENT
Between patient and Dr. Scott Graves (Triune Wellness, LLC)

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 state 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.

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, and procedural disputes will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement binds 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 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 r 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 e 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 the provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non – economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. 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 the 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 Name (or representative):
Patient Signature:

Consent To Treat Form

I hereby request and consent to the provision of services rendered by Scott Graves and/or other licensed providers at Triune Wellness, LLC.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, manual therapy, ultrasound therapy, neuromuscular reeducation and/or other physical therapy modalities, cupping therapy, bleeding therapy, Gua Sha, injection therapy, recommendations for herbs and supplements, laser therapy, injections, electrical stimulation, Tui-Na (Oriental massage), Oriental herbal medicine, nutritional counseling and other modalities within the provider's scope of practice.

I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally or in writing. The herbs may have an unpleasant smell and/or taste. I understand that post-treatment flare-ups (increased symptoms) are a normal and expected part of healing. However, I will immediately notify Triune Wellness, LLC of any increased pain or symptoms or if I am worried or concerned about any aspect of treatment or recommendations made by the provider. I understand that the support staff is not qualified to give me medical advice or treatment recommendations.

I have been informed that acupuncture and bodywork are generally safe methods of treatment, but that they may have some side effects, including but not limited to, soreness, bruising, numbness, or tingling near the needling sites of needle insertion or manual work, dizziness, or fainting. Bruising and tenderness are common side effects of acupuncture, injections, and massage, and physical medicine modalities. Rare or 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 disposable sterile needles and maintains a clean and safe environment. Some potential risks of injections of any type are bruising, tenderness, allergic reaction to products or devices, numbness, muscle soreness, or nerve damage.

Burns and/or scarring are a potential risk of moxibustion and fire cupping. 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, synthetic, and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I agree to inform the provider at the time of product recommendation if I am on blood thinners, have a heart condition, am breastfeeding, have diabetes, or am on any medications, though ultimately it is my responsibility to research herb-drug interaction before choosing to take any herbs, vitamins or supplements that are recommended.

I understand that 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 or are nursing, on blood thinners, have a change in medication, new diagnosis or symptoms, change in symptoms, have or get a pace-maker, have diabetes, hypertension, thyroid issues or other health conditions arise or change.

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 results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports and my records may be shared with my insurance company to facilitate payment but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show 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 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.

Date:
Patient Name (Printed):
Patient Name (Signed):