

ACUPUNCTURE- PRACTICE MEMBER INFORMATION

| | | | | | |
|---|-------------|---------------------|-------------|--------|--|
| NAME: | | | DATE: | | |
| ADDRESS: | | CITY: | STATE: | ZIP: | |
| HOME PHONE | WORK PHONE: | | CELL PHONE: | | |
| BIRTH DATE: | AGE: | SOCIAL SECURITY NO: | | | |
| EMAIL ADDRESS: | | | | | |
| MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED OTHER_____ | | | | | |
| | | | | | |
| OCCUPATION: | | | EMPLOYER: | | |
| IN CASE OF EMERGENCY NOTIFY (NAME) | | | | PHONE: | |
| PERSON RESPONSIBLE FOR YOUR ACCOUNT | | | | | |
| INSURANCE COMPANY (PLEASE GIVE FRONT DESK COPY OF YOUR CARD) | | | | | |
| REFERRED BY: | | | | | |
| HOW MANY CHILDREN DO YOU HAVE? | | | | | |
| PRESENT HEALTH CHALLENGE(S) | | | | | |
| PRIMARY HEALTH CONCERN | | | | | |
| HOW DID THIS HAPPEN? | | | | | |
| HOW LONG HAS THIS BEEN GOING ON? | | | | | |
| WHAT MAKES IT BETTER? | | | WORSE? | | |
| SEVERITY (ON A SCALE OF 1-10, 10 BEING MOST SEVERE) 1 2 3 4 5 6 7 8 9 10 | | | | | |
| HAVE YOU SEEN ANYONE ELSE FOR THIS CONDITION? WHAT ELSE HAVE YOU BEEN DOING OT HELP? (DRUGS, HEAT, ICE, ETC.) | | | | | |
| OTHER HEALTH CONCERNS: | | | | | |
| HOW DO THESE CONDITIONS IMPAIR YOUR DAILY ACTIVITIES? | | | | | |
| HAVE YOU HAD ACUPUNCTURE OR CHIROPRACTIC BEFORE? Y OR N IF SO, PLEASE DESCRIBE YOUR EXPERIENCE: | | | | | |
| WHAT IS YOUR GOAL FOR CARE? RELIEF OF SYMPTOMS ONLY / CORRECTION & STABILIZATION OF PROBLEM / PREVENTION, WELLNESS & SUPPORTIVE CARE (PLEASE CIRCLE ONE) | | | | | |

CHEMICAL STRESS

PLEASE LIST ANY MEDICATIONS AND/OR SUPPLEMENTS YOU ARE CURRENTLY TAKING

| DRUG/SUPPLEMENT | REASON | HOW LONG | DOSE | FREQUENCY |
|---|--------|------------------------|--------------------------|-----------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| USE OF ALCOHOL: <input type="checkbox"/> NEVER <input type="checkbox"/> RARELY <input type="checkbox"/> MODERATE <input type="checkbox"/> DAILY | | | | |
| USE OF TOBACCO: <input type="checkbox"/> NEVER <input type="checkbox"/> PREVIOUSLY, BUT QUIT <input type="checkbox"/> CURRENT PACKS/DAY _____ | | | | |
| USE OF CAFFEINE: <input type="checkbox"/> COFFEE <input type="checkbox"/> TEA <input type="checkbox"/> SODA <input type="checkbox"/> HOW MUCH? _____ | | | | |
| USE OF DRUGS: <input type="checkbox"/> NEVER <input type="checkbox"/> TYPE/FREQUENCY _____ | | | | |
| EXPOSURE TO: <input type="checkbox"/> FUMES <input type="checkbox"/> DUST <input type="checkbox"/> SOLVENTS <input type="checkbox"/> AIRBORNE PARTICLES <input type="checkbox"/> NOISE | | | | |
| TYPICAL BREAKFAST: | | | | |
| TYPICAL LUNCH: | | | | |
| TYPICAL DINNER: | | | | |
| SNACKS: | | | | |
| HOBBIES OR OTHER RECREATION: | | | | |
| PHYSICAL EXERCISE: Y OR N WHAT? | | | | |
| HOURS OF WORK PER WEEK? | | DO YOU LIKE YOUR WORK? | | |
| STRESS: <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> HIGH | | | WHAT CAUSES YOUR STRESS? | |

HEALTH HISTORY

PLEASE CHECK IF YOU HAVE HAD THE FOLLOWING

| | | | | | |
|--|---|--|---|---|--|
| <input type="checkbox"/> MEASLES | <input type="checkbox"/> VENEREAL DISEASE | <input type="checkbox"/> BLOOD DISORDER/ TRANSFUSION | <input type="checkbox"/> PARALYSIS | <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> POLIO |
| <input type="checkbox"/> MUMPS | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> VEIN CONDITION | <input type="checkbox"/> STROKE | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> EYE PROBLEMS |
| <input type="checkbox"/> CHICKENPOX | <input type="checkbox"/> MIGRAINES | <input type="checkbox"/> BACK TROUBLE | <input type="checkbox"/> ULCER | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HERNIA |
| <input type="checkbox"/> DIPHTHERIA | <input type="checkbox"/> DIABETES | <input type="checkbox"/> HEMORRHOIDS | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> EATING DISORDER |
| <input type="checkbox"/> SMALLPOX | <input type="checkbox"/> CANCER OR TUMOR | <input type="checkbox"/> HIGH/LOW BLOOD PRESSURE | <input type="checkbox"/> THYROID DISEASE | <input type="checkbox"/> HIV+ | <input type="checkbox"/> ADDICTION |
| <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> PERSISTAND COUGH | <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> HIVES OR ECZEMA | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HEPATITIS A B C |
| <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> GOUT | <input type="checkbox"/> ORGAN TRANSPLANT | <input type="checkbox"/> BLADDER INFECTIONS | <input type="checkbox"/> STOMACH PROBLEMS | <input type="checkbox"/> WHOOPING COUGH |
| <input type="checkbox"/> OTHER: | | | | | |

| PREVIOUS HOSPITALIZATIONS/SURGERIES | WHEN? |
|---|-----------------------------------|
| | |
| | |
| | |
| I AM TAKING COUMADIN/WARFARIN? Y OR N | I HAVE A PACEMAKER ? Y OR N |

REVIEW OF SYSTEMS

PLEASE INDICATE ANY PERSONAL HISTORY BELOW BY CHECKING NEXT TO THE SYMPTOM

WATER ELEMENT

- COLD HANDS/FEET
- SWEATY HANDS/FEET
- HOT/COLD INTOLERANCE
- HOT FLASHES
- NIGHT SWEATS
- HEAT IN CHEST
- THIRSTY
- LACK OF PERSPIRATION
- PERSPIRE EASILY
- TOOTH PROBLEMS/CAVITIES
- EASY BROKEN BONES
- SORE/WEAK KNEES
- COLD SENSATION IN KNEES
- LOW BACK PAIN/WEAKNESS
- MEMORY PROBLEMS
- HAIR LOSS/PREATURE GREY
- LOW-PITCHED EAR RINGING
- BACK OF HEAD HEADACHE
- KIDNEY STONES
- BLADDER INFECTIONS
- NIGHT TIME URINATION
- LACK OF BLADDER CONTROL
- DARK &/OR SCANTY URINE
- CLEAR &/OR PROFUSE URINE
- REDDISH/BROWN URINE
- CLOUDY URINE
- STRONG ODOR OF URINE
- BURNING OR PAINFUL URINE
- BLOOD IN URINE
- FREQUENT URINATION
- SEXUAL DIFFICULTY
- HIGH/LOW LIBIDO

METAL ELEMENT

- GENERAL WEAKNESS
- SHORTNESS OF BREATH
- EASY TO CATCH COLDS
- LOW ENERGY
- FEEL WORSE AFTER EXERCISE
- NASAL DISCHARGE
- COUGH
- NOSE BLEEDS
- SINUS INFECTION
- DRY MOUTH/THROAT
- SORE THROAT
- DRY SKIN
- SNEEZING
- ALLERGIES
- SINUS HEADACHE
- OVERALL BODY ACHES
- TIGHT NECK/SHOULDERS
- DIFFICULTY BREATHING
- LOOSE STOOLS
- CONSTIPATION
- BLOOD IN URINE
- DIARRHEA
- BLOOD/MUCUS IN STOOL
- UNDIGESTED FOOD IN STOOL

EARTH ELEMENT

- LOW APPETITE
- SUDDEN WEIGHT GAIN
- SUDDEN WEIGHT LOSS
- GAS
- BLOATING
- GURGLING IN STOMACH
- FATIGUE AFTER EATING
- PROLAPSED ORGANS
- HERNIAS
- EASY BUIISING
- HEMORRHOIDS
- HEAVINESS IN LIMBS/BODY
- MENTAL HEAVINESS
- MENTAL FOGGINESS
- SWOLLEN HANDS/FEET
- CHEST CONGESTION
- NAUSEA
- SNORING
- HEART BURN
- LARGE APPETITE
- BAD BREATH
- BLEEDING GUMS
- ACID REGURGITATION
- ULCER
- BELCHING
- HICCOUGHS
- STOMACH PAIN
- VOMITING

WOOD ELEMENT

- CHEST PAIN
- RIB SIDE PAIN
- BITTER TASTE IN MOUTH
- DEPRESSION
- IRRITABILITY
- SKIN RASHES
- TEMPORAL HEADACHE
- HEADACHE AT THE TOP OF HEAD
- TINGLING SENSATIONS
- MUSCLE CRAMPS
- MUSCLE SPASMS
- DIZZINESS
- SEIZURES
- CONVULSIONS
- NECK TENSION
- SHOULDER TENSION
- EAR RINGING (HIGH)
- GALL STONES
- BLURRY VISION
- BLACK SPOTS IN VISION
- BLOODSHOT EYES
- DRY EYES
- GRITTY EYES
- BREAST TENDERNESS
- BRITTLE NAILS
- BLOATING
- LUMP IN THROAT

FIRE ELEMENT

- PALPITATIONS
- ANXIETY
- MOUTH SORES
- RESTLESSNESS
- MENTAL CONFUSION
- CHEST PAIN
- FREQUENT DREAMS
- INSOMNIA
- SPEECH PROBLEMS

EMOTIONS

- FEARS
- PHOBIAS
- GREIF
- MELANCHOLY
- ANGER
- WORRY
- OVER THINKING
- LACK OF JOY/HUMOR
- LAUGH FOR NO APPARENT REASON

ALLERGY

- HISTORY OF REACTION TO:
- ANTIBIOTICS
- PENICILLIN
- NARCOTICS
- OTHER _____

MEN ONLY

- IMPOTENCE
- PROSTATE PROBLEMS
- TESTICULAR PAIN
- TESTICULA SWELLING
- COLD/NUMB IN EXTERNAL GENITALIA

WOMEN ONLY

ARE YOU PREGNANT? Y N
BIRTH CONTROL METHOD _____

OF CHILDREN _____

AGES? _____

OF ABORTIONS _____

OF MISCARRIEAGES _____

AGE OF 1ST PERIOD _____

AGE OF MENOPAUSE _____

LAST PAP SMEAR _____

ABNORMAL? Y N

DAYS OF FLOW _____

DAYS OF CYCLE _____

DO YOU EXPERIENCE:

- HEAVY PERIODS
- LIGHT PERIODS
- PAINFUL PERIODS
- IRREGULAR PERIODS
- PMS
- VAGINAL DISCHARGE
- INFERTILITY
- BREAT LUMPS
- NIPPLE DISCHARGE
- VAGINAL DISCHARGE
- FIBROIDS
- ENDOMETRIOSOS
- PCOS
- CRAMPS BEFORE PERIOD
- CRAMPS DURING PERIOD
- PAIN IN INNER THIGH
- CLOTS

KNOWN FOOD ALLERGIES

RELEASE

To the best of my knowledge, the questions on this forms have been accurately answered. I understand that it is my responsibility to inform the Doctor of any changes in my health status.

Signature _____

Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures (or the patient named below for whom I am legal responsible) by the Oriental Medicine Doctor named below and/or other Oriental Medicine Doctors who now or in the future treat me while working or associated with, or serving as a back up for the Oriental Medicine Doctor named below. Whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, exercise therapy, Tut-Na, Chinese or Western herbal therapy and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including bruising, numbness, or tingling near the needling sites that may last a few days and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained or removed. Bruising is a common side effect of cupping and gua sha. Unusual and rare risk of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while their document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral and animal 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue.

I understand that the herbs need to be consumed according to the instructions provided orally and/or in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the Oriental Medicine Doctor of any unanticipated or unpleasant side effects associated with the consumption of herbs. I will notify the Oriental Medicine Doctor if I become pregnant.

I do not expect the Oriental Medicine Doctor to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the Oriental Medicine Doctor to exercise judgment during the course of treatment, which the Oriental Medicine Doctor thinks at the time, based on the facts known, and is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below, I show that I have read, or have had read to me, his 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.

Print Name of Patient

Print Name of Oriental Medicine Doctor

Signature of Patient

Signature of Oriental Medicine Doctor

Date Consent Completed

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):

RELATIONSHIP TO PATIENT:

SIGNATURE:

DATE: