CHINESE MEDICINE

THE ACUPUNCTURE CLINIC

PATIENT HISTORY

This clinic specializes in acupuncture and herbal care. We ask you to fill out this form for either consultation or examination purposes. Examinations are done routinely to determine the nature and extent of the problem. The acupuncturist will explain the level of examination necessary for your type of condition.

NAME_____DATE _____

ADDRESS_____CITY_____STATE_____

ZIP_____ PHONE_____ WORK_____CELL_____

E-MAIL_____BIRTHDATE_____MARITAL STATUS_____

NO.OFCHILDREN_____OCCUPATION_____

EMPLOYER_____

PRIMARY PHYSICIAN (Name & No.):_____REFERRED BY_____

EMERGENCY CONTACT (Name & No.):_____

PURPOSE FOR COMING_____

SECONDARY COMPLAINT_____ DOCTOR'S DIAGNOSIS_____

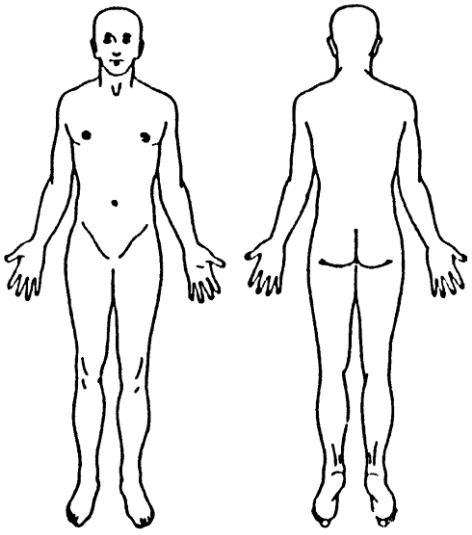
How did this condition develop? _____

_____

When was the first time you were aware of this condition? _____

_____

If you are in pain, please mark the exact location of your pain on the figure below. Describe the type, frequency, intensity and duration of your pain, as well as any activity that brings on or aggravates the pain. (i.e. sharp abdominal pain, every 30 seconds, for the last two hours when standing or sitting.



What type of service do you desire?

_____1) Temporary relief of symptoms/pain control

_____2) Eradication of tendencies causing condition

_____3) Balanced optimum health—elimination of root cause of problem, if possible

_____4) Maintenance care—regular balancing to keep in good health

Have you ever received treatment for this condition? ____Yes ____No

If so, where _____

By Whom: _____

What were the results of treatment? _____

_____

Has the condition been getting___ better, ___ worse, or ___ staying the same?

Has this condition affected your___ home life, ___ work, ___ social life,

___ ability to exercise, ___ rest, or ___ sleep?

This is not a detailed history. Please circle all of the conditions below that apply to you.

Tendency to faint, tendency to bruise or discolor easily, tendency to bleed for a long time, hepatitis, AIDS, high blood pressure, heart problems, respiratory problems, treated by acupuncture before, presently using other therapies, past surgeries, taking medications, hungry at present time, exhausted at present time, nervous at present time.

☯ Please note that occasionally some people experience minor bleeding or a tiny bruising from gently piercing the skin. This does not adversely affect your health; on the contrary, it can promote healing.

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PATIENT PROFILE

It is very important in Chinese Medicine to know how long a patient has experienced his/her symptoms. Therefore, it is essential to indicate time on the symptoms.

Indicate with one **(x)** check any condition that you sometimes experience; use two **(xx)** checks for those conditions that often occur; and three **(xxx)** checks for symptoms that are a major concern.

WATER ELEMENT

☐☐☐ Hearing Loss
☐☐☐ Dizziness
☐☐☐ Lower backache with neck pain
☐☐☐ Sinus congestion
☐☐☐ Edema
☐☐☐ Under eye darkness
☐☐☐ Emotional instability
☐☐☐ Aversion to cold
☐☐☐ Hair thinning or loss
☐☐☐ Premature aging
☐☐☐ Frequent urination
☐☐☐ Kidney stones
☐☐☐ Perspire very easily
☐☐☐ Weakness of legs/knees
☐☐☐ Asthmatic cough
☐☐☐ Rapid weight change
☐☐☐ Loose teeth
☐☐☐ Reduced sexual energy
☐☐☐ Thyroid Problems
☐☐☐ Diabetes

WOOD ELEMENT

☐☐☐ Headaches
☐☐☐ Migraines
☐☐☐ Ringing in ears
☐☐☐ Poor eyesight
☐☐☐ Dry eyes
☐☐☐ Eczema
☐☐☐ Shingles
☐☐☐ Herpes simplex
☐☐☐ Warts
☐☐☐ Nervousness
☐☐☐ Convulsion, spasms
☐☐☐ Irritability
☐☐☐ Hemorrhoids
☐☐☐ Hepatitis
☐☐☐ Ulcer
☐☐☐ Vomiting
☐☐☐ Gallstones
☐☐☐ Indecisive
☐☐☐ Fullness below ribs
☐☐☐ Shoulder/neck tension
☐☐☐ Insomnia

FIRE ELEMENT

☐☐☐ Dry scalp
☐☐☐ Skin eruptions, rashes
☐☐☐ Cysts, tumors
☐☐☐ Ear Infections
☐☐☐ Sore throat, tonsillitis
☐☐☐ Lymphatic swelling
☐☐☐ Hot palms & soles
☐☐☐ Heart palpitations
☐☐☐ Aversion to heat
☐☐☐ Bitter taste
☐☐☐ Gum problems
☐☐☐ Nose bleed
☐☐☐ Facial redness
☐☐☐ Itching/burning skin
☐☐☐ Hot hands/feet
☐☐☐ Thirst
☐☐☐ Vivid dreaming
☐☐☐ Dark urine
☐☐☐ Night sweats

EARTH ELEMENT

☐☐☐ Indigestion
☐☐☐ Flatulence
☐☐☐ Food Allergy
☐☐☐ Stomach ache/ulcer
☐☐☐ Diarrhea
☐☐☐ Anemia
☐☐☐ Halitosis
☐☐☐ Mouth sores
☐☐☐ Heartburn
☐☐☐ Strong appetite
☐☐☐ Weak appetite
☐☐☐ Nausea
☐☐☐ Abdominal bloating
☐☐☐ Low body weight

METAL ELEMENT

☐☐☐ Bronchitis
☐☐☐ Asthma
☐☐☐ Shallow breathing
☐☐☐ Cough
☐☐☐ Sinus Congestion
☐☐☐ Nasal infections

OTHER

☐☐☐ Fatigue
☐☐☐ Arthralgia
☐☐☐ Sciatica/nerve pain
☐☐☐ Cold hands/feet
☐☐☐ Tendonitis
☐☐☐ Bursitis

PAIN & COMMENTS

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Current prescriptions medication (i.e. hormones): _____

_____

Over-the-counter:

_____

FAMILY MEDICAL HISTORY: (check any that apply)

Cancers ____ Cardiovascular Disease ____ Osteoporosis ____ Obesity ____ Alcoholism ____ Mental Illness/Depression _____

Alzheimer's _____ Diabetes _____ Arthritis _____ Stroke _____ Others _____

STRESS:

Rate the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest) _____ Identify the major causes

_____

_____

SLEEP

Time go to bed____ **Get up** ____ **Wake up at night** ____ **Hard to fall asleep** ____ **Night Urination**____

How many times per night ____

WHAT DO YOU EAT REGULARLY?

Breakfast: _____Time:_____

Lunch: _____Time:_____

Dinner: _____Time:_____

How many meals do you eat per day _____ Dine out per week _____

WHAT DO YOU DRINK REGULARLY?

Water_____Amount per day_____ Soft Drinks: Type _____ How many per day _____

Coffee _____ No. of cups per day _____ Strong _____ Mild _____ Decaffeinated _____

Drink alcohol _____ how many oz. per day/week _____ Preference _____

Exercise Type _____How many times per week _____

Use tobacco/smoke cigarettes _____How many cigarettes per day _____ Exposed to passive smoke _____

DO YOU RESTRICT YOUR INTAKE OR AVOID COMPLETELY: (check any that apply)

Refined Sugar ___Refined Carb ___Refined Salt ___Refined Oil___Dairy products ___Others _____

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WOMEN'S HEALTH SCREEN

GYNECOLOGICAL HISTORY: (check any that apply)

Date of last gynecological exam (PAP, mammogram) _____Results _____Age of first period _____

Date of last menstrual cycle _____Length of cycle _____ Interval of time between cycles _____

Any recent changes in normal menstrual flow _____Form of birth control _____

No. of children ____No. of pregnancies____ C-section ____Surgical menopause/date _____

Other surgeries _____

☐Endometriosis ☐Infertility ☐ Fibrocystic Breasts ☐Fibroids/Ovarian Cancer ☐ Reproductive Cancer ☐ Vaginal Infections

☐ Vaginal Candidacies ☐ Genital Herpes ☐Pelvic Inflammatory Disease

Part 1

*Check the symptoms you experience regularly one **to two weeks before** your period:*

1. ____ Anxiety
2. ____ Irritability
3. ____ Nervous Tension
4. ____ Aggressive or hostile towards family or friends
5. ____ Engage in self-destructive behavior
6. ____ Weight gain
7. ____ Water retention
8. ____ Abdominal bloating
9. ____ Tender, swollen and/or painful breasts
10. ____ Breast lumps increase in size and tenderness
11. ____ Discharge from nipples
12. ____ Craving for sweets
13. ____ Increased appetite
14. ____ Heart palpitations
15. ____ Fatigue
16. ____ Headaches
17. ____ Shaky or clumsy
18. ____ Depressed
19. ____ Withdrawn
20. ____ Confused
21. ____ Insomnia/difficulty sleeping

Part 2

Check the symptoms and/or behaviors that occur during your period with a frequency or intensity that affects our daily activities:

1. ____ Cramping in lower abdomen or pelvic area
2. ____ Sharp intermittent pain
3. ____ Dull aching pain
4. ____ Upset stomach

(Part 2, continued)

5. ____ Diarrhea
6. ____ Nausea or vomiting
7. ____ Low back aches
8. ____ Headaches
9. ____ Difficulty concentrating
10. ____ Accident prone
11. ____ Unusual fatigue (napping)
12. ____ Decreased productivity
13. ____ Weight gain
14. ____ Painful and/or swollen breasts
15. ____ Irritability
16. ____ Mood swings
17. ____ Depression
18. ____ Painful intercourse

Part 3

*Check off any of the following statements **that describe** your menstrual cycle, energy level or reproductive function:*

1. ____ Heavy prolonged menstrual bleeding/clotting
2. ____ Menstrual bleeding that lasts longer than 5 days
3. ____ Absence of periods for 3 months or more
4. ____ Vaginal itching, burning, dryness
5. ____ Menstruation that occurs too frequently (every 21-24 days)
6. ____ Irregular periods (once every 3 to 6 months)
7. ____ Frequently skip periods
8. ____ Menstrual cycle every 36 days or longer
9. ____ Unusually light or heavy periods
10. ____ Unusually light menstrual flow – spotting
11. ____ Menses last 3 days and are light
12. ____Bleeding or spotting between a period
13. ____Frequent urination
14. ____Bleeding between periods - light/staining
15. ____Bleeding between periods - heavy and/or clots
16. ____Abnormal vaginal discharge

Part 4

***Check any of the following symptoms if they occur** throughout the month with an intensity or frequency that affects your ability to perform your daily activities or feel good about yourself.*

1. ____ Decline of vital energy and sense of well-being
2. ____ Hot flashes
3. ____ Night sweats
4. ____ Spontaneous sweating
5. ____ Chills
6. ____ Depressed
7. ____ Irritable
8. ____ Anxiety
9. ____ Anger
10. ____ Mood Swings
11. ____ Headaches
12. ____ Forgetful
13. ____ Difficulty concentrating
14. ____ Difficulty sleeping
15. ____Urinary problems
16. ____ Vaginal problems
17. ____ Dry skin
18. ____ Bleeding between periods
19. ____ Irregular periods
20. ____ Stopped menstruating
21. ____ Joint and muscle pain
22. ____ Change in sexual desire
23. ____ Difficulty with orgasm
24. ____ Painful intercourse
25. ____ Loss of muscle tone
26. ____ Vaginal bleeding
27. ____ Vaginal bleeding after sex
28. ____ Vaginal discharge

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MEDICAL HISTORY

Please list any significant illnesses, surgeries, or accidents.

Age 0-6:

Age 7 – 12:

Age 13 – 20:

Age 21 – 30:

Age 31 – 40:

Age 41 to present:

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CONSENT FOR TREATMENT

Consent for Acupuncture Care: I, the undersigned am aware of both the benefits and risks of acupuncture treatment and give my consent for treatment. I fully understand that there is no implied or stated guarantee of success of effectiveness of a specific treatment or series of treatments. I further understand that the services from this clinic are alternative approaches of my personal choice to support my optimal health; the services are not intending to change or replace any procedure and medication from my physician. And I am aware of that I may seek a second opinion from another health care professional or may terminate therapy at any time.

Patient/Responsible Party Signature: _____**Date** _____

It is Agreed with regard to medical care and services the ATTENDING ACUPUNCTURIST will provide services to the patient to the best of his/her skill and knowledge of medical care in the light of circumstances, which is possible and practical. The PATIENT will cooperate fully with the acupuncturist by following his/her instructions.

It is also Agreed: I agree to hold harmless this acupuncturist or to present any issue or concerns of medical malpractice by letter to the acupuncturist and, if taken further, it will be decided by neutral arbitration; and therewith give up my right to jury or court trial should an issue arise. Because of the differences in human consultation and response, I understand that there is no way possible to warrant the outcome of such medical care and service.

Patient/Responsible Party Signature: _____**Date** _____

I understand that insurance benefits are a contract between the patient and the insurance carrier; I am responsible for paying all charges, including co-payments and deductible at the time of service. I am also aware that if insurance does not cover services, or if the physician does not accept assignment, I am responsible for the charges. I authorize payment of insurance benefits directly to The Acupuncture Clinic. I hereby authorize release of medical information needed to complete insurance company claim inquiries, including release of information to the medical billing firm.

Patient/Responsible Party Signature: _____**Date** _____

Disclosure Form: By signing below, I acknowledge having read the Disclosure Form and I have had the opportunity to ask questions.

Patient/Responsible Party Signature: _____**Date** _____

Notice of Privacy Practices: By signing below, I acknowledge having read the Notice of Privacy Practices. (Patient may request a copy of Notice of Privacy Practices for their records.)

Patient/Responsible Party Signature: _____**Date** _____

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FINANCIAL POLICY

Thank you for choosing us as a health care provider. We are committed to your treatment being successful. An understanding of our financial policy is a very important part of your care.

Late Policy: All efforts are made to keep our schedules on time; if you are more than 15 minutes late, every effort will be made to fit you into the schedule; however, there is no guarantee that you will be seen immediately.

Missed Appointments: It is required that patients attend all scheduled appointments. If a patient is unable to keep a scheduled appointment, the patient is required to call and cancel the appointment at least 24 hours in advance. **Failure to cancel an appointment within 24 hours will result in the assessment of a $25.00 fee.** This fee is due when billed or at the patient's next appointment, whichever comes first.

Payment Policy: Patients are responsible for any and all fees incurred as a result of treatment, regardless of insurance coverage. This includes, but is not limited to, payment of co-payments at the time of service, and full financial responsibility for any balance due after the insurance pays or denies claims submitted. Balances are due upon notification. Balances over thirty (30) days old will accrue a 1.5% interest per month. Insurance benefits are a matter between you and your insurance company. You are ultimately responsible for payment on your account.

If your account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, you will be responsible for all costs of collection, including, but not limited to interest, rebilling fees, court costs, attorney fees and collection agency costs.

Pre-Authorization & Referrals: If your insurance requires referrals or pre-authorization for the coverage of Acupuncture treatment(s), it is your responsibility to request such authorization from your doctor, before your Acupuncture visit.

Payment may be made by cash, checks, Visa or MasterCard.
There is a $20 fee for any checks returned by the bank.

By signing below, I acknowledge that I have read and understand the Financial Policy.

Patient/Responsible Party Signature: _____Date: _____

As a courtesy, we place Reminder Calls to patients the business day before their appointment. All efforts are made to either speak with patient, or leave a message with Appointment Date & Time. Please indicate if you wish to receive these Reminder Calls and if so, which phone number you wish for us to use:
□ **Yes**, I wish to receive Appointment Reminder Calls at this phone number: _____
□ **No,** I do not wish to receive Appointment Reminder Calls

☯We send out holiday and birthday gift certificate, as well as other promotion notes via E-mail, if you wish to receive these, please **print** your E-mail here_____

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