

W e l c o m e

Patient Information

| | | | | | |
|----------------------------|---|---------------------------------------|--|--|---|
| First name | <input type="text"/> | Middle | <input type="text"/> | Last Name | <input type="text"/> |
| Gender | <input type="checkbox"/> F <input type="checkbox"/> M | Date of birth | <input type="text"/> | Or SSN | <input type="text"/> |
| Address | <input type="text"/> | | | | |
| City | <input type="text"/> | State | <input type="text"/> | Zip | <input type="text"/> |
| Home Ph. | <input type="text"/> | Cell Ph. | <input type="text"/> | Work Ph. | <input type="text"/> |
| Email | <input type="text"/> | | | Status | <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other |
| Employment | <input type="checkbox"/> Employed | <input type="checkbox"/> Not employed | <input type="checkbox"/> Full time student | <input type="checkbox"/> Part-time student | <input type="checkbox"/> Retired |
| Employer/School name | <input type="text"/> | | | | |
| Occupation | <input type="text"/> | | | | |
| How did you hear about us? | <input type="checkbox"/> Referral by: | <input type="checkbox"/> Phone book | <input type="checkbox"/> Web | <input type="checkbox"/> Insurance | |

Emergency Contact

| | | | |
|-------------------|----------------------|--------------|----------------------|
| First & Last Name | <input type="text"/> | Relationship | <input type="text"/> |
| Home Ph. | <input type="text"/> | Work Ph. | <input type="text"/> |
| | | Cell Ph. | <input type="text"/> |

Insurance Information – (please bring your insurance card for your first visit)

| | | | | |
|---|--|-----------------------------------|--|--|
| <input type="checkbox"/> AETNA | <input type="checkbox"/> CIGNA | <input type="checkbox"/> MEDICAID | <input type="checkbox"/> MULTIPLAN | <input type="checkbox"/> OTHER (specify) |
| <input type="checkbox"/> BEECH STREET / EBC | <input type="checkbox"/> LOVELACE | <input type="checkbox"/> MEDICARE | <input type="checkbox"/> PRESBYTERIAN | |
| <input type="checkbox"/> BLUE CROSS & BLUE SHIELD | | | <input type="checkbox"/> UNITED HEALTHCARE | |
| ID # | <input type="text"/> | Group # | <input type="text"/> | |
| Are you the primary on this plan? | <input type="checkbox"/> Yes (SELF) <input type="checkbox"/> No – please provide us with the policy holder information - below | | | |

Policy holder information

| | | | | | |
|---------------------------------|--|---------------|----------------------|-----------|----------------------|
| Patient relationship to insured | <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (please specify) | | | | |
| Insurance | <input type="text"/> | ID # | <input type="text"/> | Group # | <input type="text"/> |
| First name | <input type="text"/> | Middle | <input type="text"/> | Last Name | <input type="text"/> |
| Gender | <input type="checkbox"/> F <input type="checkbox"/> M | Date of birth | <input type="text"/> | Status | <input type="text"/> |
| Address | <input type="text"/> | | | | |
| City | <input type="text"/> | State | <input type="text"/> | Zip | <input type="text"/> |
| Home Ph. | <input type="text"/> | Cell Ph. | <input type="text"/> | Work Ph. | <input type="text"/> |

Insurance Assignment & Release

I authorize the release of any medical or other information necessary to process my medical claims to my insurance plan. I authorize payment of medical benefits to the above mentioned physician and understand that I am responsible for the payment of any co-pay, co-insurance, or services not covered by my insurance plan.

X

Patient Personal Health History

What is the main condition(s) you would like to treat today?

Date of current ILLNESS (first symptoms) / **INJURY / PREGNANCY**

Is your condition related to:

| | | |
|--|---|--|
| <p>a. Employment? (Current or previous)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>b. Auto accident?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No State:</p> | <p>c. Other accident?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Details:</p> |
|--|---|--|

Current diagnosed conditions:

Which medications are you currently taking and for which conditions?(attach a separate sheet if necessary)

List sensitivity to any medication:

List your allergies (What and since when?)

Past Significant Health Problems - condition & year/age (illness, injury, surgeries, broken bones, accidents, etc)

Primary Care Physician

| | | |
|------------|-----------|-------------|
| First name | Last name | Institution |
| Address | | |
| Phone | Fax | e-mail: |

Accident Claim

| | |
|---|--|
| Referring physician | |
| Medical Claim # | |
| Who will process your claim if not your health insurance plan? <i>Please provide name & address</i> | |

Personal Health History

| Do you suffer from? | Year/ Age | Currently | Past | Never | Do you suffer from? | Year/ Age | Currently | Past | Never |
|----------------------|--------------|--------------------------|--------------------------|--------------------------|--|--------------|------------------------------|-----------------------------|--------------------------|
| Stroke | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Meningitis | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anorexia | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bulimia | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Headache | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Migraine | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Antibiotic use | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ear Infection | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Drug abuse | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Amenorrhea (no periods) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dysmenorrhea painful periods | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fibromyalgia | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irregular periods | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Multiple sclerosis | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Spontaneous abortion | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness / Vertigo | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hot flashes | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Light Headedness | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | PMS | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Insomnia | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Breast pain | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sprain | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Organ prolapse | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint pain | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Broken bones | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Upper back pain | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lower back pain | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tremors | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Abdominal pain | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent colds/flu | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Indigestion | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Conjunctivitis | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Constipation | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Significant Weight <input type="checkbox"/> gain <input type="checkbox"/> loss | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diarrhea | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Spontaneous sweating | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Polio | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Night sweating | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chickenpox | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Poor vision | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mumps | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Poor night vision | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Measles | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep walking | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep talking | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Typhoid fever | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mood swings | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bleed easily | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental disorders | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? Due date: | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

Check illness(es) which have occurred in any of your blood relatives:

- Alcoholism
 Bleed easily
 Diabetes
 Heart disease
 Kidney disease
 Obesity
 Allergy
 Cancer
 Epilepsy
 High blood pressure
 Mental illness
 Stroke
 Other:

Informed Consent

I here by 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 names below, for whom I am legally responsible) by the acupuncturist named above 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 above, including those working at the clinic or office listed above 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 (Oriental Massage), Oriental 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 be 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 have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. 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 sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and 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 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 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.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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, 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.

Glossary

- **Acupuncture:** is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolves with pressing dry cotton on the spot where the skin is bleeding. It is also normal for the patient to have a temporary warm, tight, sore or tingling sensation at the acupuncture site
- **Acupressure/TuiNa** involves rubbing, kneading, pressing, and stroking, etc., which may result in muscle soreness at the massage site that can last several days. This technique may require disrobing. I understand all attempts will be made to assure my privacy
- **Indirect Moxibustion** requires burning an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of skin contact and mild burns exists.
- **Cupping** involves a localized suction produced by heating a small glass cup. There is a possibility that local bruising is likely to occur at the site where Gua Sha is performed
- **Tapping, Plum Blossom, Bleeding, Pricking** all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment site is likely occurrence. Only single-use needles are used in these procedures.
- **Electrical Stimulation/TENS** uses microcurrent electricity to stimulate acupuncture points. A mild tingling sensation of electricity will be felt
- **Treatment Using Control Points Ren 1/Du 1** In very rare cases, the Acupuncture provider may recommend treatment using acupuncture points near the genital organs. If this is necessary, the Acupuncture provider will notify me and will provide alternative treatments if I am uncomfortable with treatment using these points. I understand all attempts will be made to assure my privacy.

Patient's first & last name _____

Patient Signature (or patient representative) **X** _____

Date _____