PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

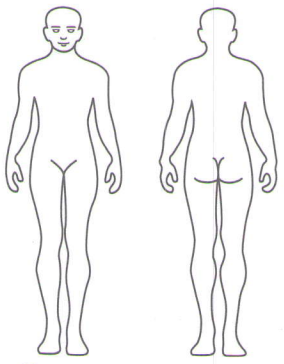
PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down




HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Cancer	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Cataracts	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

_____
_____
_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____

FOR WOMEN

Age of 1st period (menarche) _____ Are u pregnant? ☐Yes ☐No Number of pregnancies? _____
Age of last period (menopause) _____ Number of live births _____, abortions _____, Miscarriages _____
Numbers of day between periods _____ Date of last Gynecologic exam _____ Pap smear _____
Numbers of days of flow _____ Mammogram _____ Bone Density Scan _____
Color of flow _____ Results _____
Clots? ☐Yes ☐No Color _____ _____
Average number of pads use per day: 1st day _____ 2day _____ 3day _____ 4day_____ + days_____
Have u been diagnosed with: ☐Fibroids ☐Fibrocystic Breasts ☐Endometriosis ☐Ovarian Cysts ☐PID other _____
Location of pain: ☐Lower abdomen ☐lower back ☐thighs ☐other _____
Nature of pain: ***(please indicate before, during or after menses)***

Cramping_____ Stabbing_____
Burning_____ Aching_____
Dull_____ Bloating_____
Consistent_____ Intermittent_____
Bearing down sensation _____

Other Symptoms related to menses

☐Discharge ☐Vaginal dryness ☐Headache
☐Nausea ☐Constipation ☐Diarrhea
☐Swollen Breast ☐Mood swings ☐Ravenous appetite
☐Poor appetite ☐Hot flashes ☐Night sweats
☐increased libido ☐Decreased libido ☐Insomnia

FOR MEN

Date of last prostate check up _____PSA results _____ Manual prostate exam results_____
Lab results _____
Frequency of Urination daytime _____ Night time _____ Color of urine: ☐ clear ☐ murky Odor _____
Symptoms related to prostate:

☐Prostate problems ☐ Delayed stream ☐Dribbling ☐incontinence ☐Retention of Urine
☐Rectal dysfunction ☐increased libido ☐ decreased libido ☐ impotence ☐Back pain
☐ Premature ejaculation ☐Groin pain ☐Testicular pain ☐Other_____

SYMPTOM SURVEY (for everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:

no mark **( )** = never experience check mark **(√)** = sometimes experience plus sign **(+)** = frequently experience

____lack of appetite
____excessive appetite
____loose stool or diarrhea
____digestive problems, indigestion
____vomiting
____belching, burping
____heartburn/reflux
(feeling the retention
decisions of food in the stomach)
____tendency to become
obsessive in work relationships
____insomnia, difficulty sleeping
____heart palpitations
____cold hands and feet
____nightmares
____mentally restless
____laughing for no reason
____fatigue
____edema
____blood stool
____black tarry stool
____abdominal pain
____chest pain
____sciatic pain
____headaches
____pain or coldness in the genital area
____cough
____shortness of breath
____decreased sense of smell
____nasal problems
____feeling of claustrophobia
____bronchitis
____colitis or diverticulitis
____constipation
____hemorrhoids
____recent use of antibiotics
____hay fever
____dizziness
____difficult to stop bleeding
____asthma
____tendency to catch colds easily
____intolerance to weather changes
____eye problems
____jaundice (yellowish eyes
or skin)
____difficult digesting oily foods
____gall stone
____light colored stool
____soft or brittle nails
____easily angered or agitated
____difficulty in making plans or
____spasms or twitching of muscles
____low back pain
____knee problems
____hearing impairment
____ear ringing
____ kidney stones
____decreased sex drive
____ hair loss
____sudden weight loss
____sudden weight gain
____allergies
____easily bruised
____high cholesterol levels

WRITTEN DOCUMENTATION FOR EXAMINATION BY A PHYSICIAN

I, _____, have received a diagnostic examination within the past
(Print name of Patient)
six months by licensed doctor of medicine, osteopathy, chiropractic, or podiatry acting within the scope of his/her practice.

Please check YES or NO for your answer:

_____ **Yes, I have received the examination.**
_____ **No, I have not received the examination.***

** In case you checked "**NO**", you need to sign a paper of **"Recommendation for Examination by a Physician."** **

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance o acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (of on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturist who now or in the future treat me while employed by working or associated with o 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 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 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 effect 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 day 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 administration staff may review my patient records and labs 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.

_____ _____
Signature of Patient Date

Recommendation for Examination by a physician

I, **Emily Chang** recommend _____,
(Print name of Patient)

to be examined by a physician regarding the condition for which he/she is seeking

Acupuncture treatment.

I understand this recommendation.

_____ _____
Signature of Patient Date

Virginia law requires that I give this form to you if I do not have written evidence that you have received a diagnostic exam in the last six months from a licensed practitioner of medicine, osteopathy, chiropractic, or podiatry regarding the condition for which you are seeking treatment.
(Code of Virginia § 54.1-2956.9, 18 VAC 85-110-10).

_____ _____
Acupuncturist Signature Date

***CANCELLATION POLICY* AGREEMENT**

I, _____acknowledge that I am required to give at least 24 hours
(Print name of Patient)

notice if I want to reschedule/cancel my Acupuncture appointment in order for the Practitioners to be able to accommodate other patients. I acknowledge that there will be a $40.00 fee charge to my credit card if I fail to comply with this agreement.

Signature of Patient: _____

Date: _____