CHINESE ACUPUNCTURE HEALTHCARE 針灸中醫

I. TREATMENT INFORMATION AND INFORMED CONSENT

Please read this information carefully and ask your practitioner if there is anything you do not understand.

Acupuncture is performed by the insertion of pre-sterilized, disposable acupuncture needles through the skin, and/or the application of heat or electrical stimulation to certain points on the body. Your acupuncture treatment may be combined with tui-na / acupressure, Chinese herbs, moxibustion, cupping, electric stimulation, derma-friction (Gua-sha), infrared heat lamp, seven-star needling, therapeutic exercises, and dietary recommendations based on the fundamentals of Chinese Medicine. Your practitioner will explain the nature of each type of treatment as needed.

Acupuncture is generally very safe. Although rare, certain side effects may result from acupuncture and each procedure or treatment has specific risks and benefits. These potential risks may include, but are not limited to:

- Discomfort or minor pain at the site of needle insertion during treatment.
- Localized, minor bleeding, bruising or swelling.
- Minor burns with the use of moxibustion
- Possible temporary aggravation of symptoms that existed prior to treatment, then rapid recovery, known as "healing crisis"
- Infection and the risks of needling in the vicinity of an infection. To reduce the possibility of infection from acupuncture, all needles are pre-sterilized, single-use, disposable and made of surgical stainless steel. After each treatment, needles are disposed of as medical waste and never reused.
- Temporary dizziness, fainting and nausea ("needle sickness")
- Broken needles (rare with the use of disposable needles)
- Possible allergic reaction to Chinese herbal medicine, such as gas, stomachache, and nausea. All herbs dispensed at the clinic are GMP approved. Please be sure to let your practitioner know if you are taking prescription medication.
- Cupping therapy and derma-friction (Gua-sha) may produce petechiae (reddish purple marks) as part of the healing process. These will disappear in a few days.
- Seven-star needling is used to detoxify the body and stimulate the skin.

Some herbs and acupuncture points are contraindicated for certain conditions. Please inform your practitioner if you have any of the following conditions:

- If you are pregnant or breastfeeding
- If you have ever experienced seizures, fainting or panic attacks
- If you have a pacemaker or any other electrical implants
- If you have HIV/AIDS, hepatitis or a sexually transmitted disease

Your practitioner is unable to anticipate or explain all risks and complications that may occur during or after treatment. However, she will exercise judgment based on your best interests.

By voluntarily signing below, I show that I have read this consent to treatment, have been told 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 and future conditions for which I seek treatment.

_____ _____

Patient Signature Helen Law, Acupuncturist

_____ _____

Print Patient's Name Date

_____

Date

II. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

September 19, 2009

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been notified of how health information about me may be used and disclosed by this Practice, and how I may obtain access to and control this information. Furthermore, I consent to the use and/or disclosure of my health information to treat me and arrange for my medical care.

_____
Patient Signature

_____
Print Patient's Name

_____
Date

If this Notice is signed by a personal representative on behalf of the patient, complete the following:

_____
Personal Representative's Name

_____
Relationship to Patient

_____
Date

If you have any questions about this notice, please contact the office manager.

III. OFFICE FINANCIAL POLICY

Payment is due at the time services are rendered, unless prior arrangements have been made. For your convenience we accept cash, VISA, MasterCard, Discover, personal check, money order, or registered check. Due to recent increases in fees charged by the credit card processors, we regretfully cannot accept charges under $30.

We reserve the right to charge and collect fees for missed appointments. If you cancel or fail to arrive for your scheduled appointments without giving us at least twenty-four (24) hours advance notice, we reserve the right to charge you the full amount of the missed appointment. Appointments are reserved exclusively for you. As a benefit to you, we may offer to move your appointment to an earlier time if openings arise.

If your check is returned to us unpaid, a processing fee of $15 will be added to your account balance and is collectible.

I AGREE THAT I AM FULLY RESPONSIBLE FOR PAYMENT OF ANY AND ALL SERVICES RENDERED AND ANY PAYMENT OR DEDUCTIBLE THAT MY INSURANCE DOES NOT COVER.

BY SIGNING BELOW, I DECLARE THAT I UNDERSTAND THE TERMS AND CONDITIONS OF THE OFFICE FINANCIAL POLICY AS DESCRIBED HEREIN AND AGREE TO THOSE TERMS AND CONDITIONS.

_____
Patient Signature

_____
Print Patient's Name

_____
Date

CHINESE ACUPUNCTURE HEALTHCARE 針灸中醫

PATIENT INFORMATION				
NAME				
ADDRESS	(Street) (City, State, ZIP)			
TELEPHONE	✓Check your preferred contact number. ❑ Home ❑ Office ❑ Mobile			
EMAIL				
SSN		AGE	HEIGHT	WEIGHT
GENDER	❑ Male ❑ Female	DATE OF BIRTH		
OCCUPATION & EDUCATION				
MARITAL STATUS	❑ Single ❑ Married ❑ Life Partner ❑ Divorced ❑ Widowed			
DATE OF FIRST VISIT		REFERRED BY		
Have you tried the following treatments? ❑ Acupuncture ❑ Herbal Medicine ❑ Acupressure (tui na) ❑ Craniosacral				

EMERGENCY CONTACT	PRIMARY PHYSICIAN'S INFORMATION
Name: _____	Name: _____
Telephone: _____	Telephone: _____
Address: _____	Address: _____
_____	_____
_____	_____

Medications, supplements, or herbs currently taking:	

MAJOR OR PRIMARY COMPLAINT

1._____

2._____

3._____

When did you first notice this problem?_____

How long have you had this problem? _____

What makes it better? What makes it worse? _____

On a scale of 1 to 10, with 10 being the worst, how would you rate the pain?_____

Have you experienced this problem in the past? _____

MEDICAL HISTORY

- ❑ Allergies
- ❑ Hepatitis (A / B / C / D)
- ❑ Seizures
- ❑ Venereal disease (STIs)
- ❑ Significant trauma
- ❑ Reactions to vaccinations
- ❑ Cancer
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Rheumatic fever
- ❑ Thyroid disease
- ❑ Childhood illnesses
- ❑ Diabetes
- ❑ Heart disease
- ❑ Birth trauma
- ❑ Ulcers
- ❑ HIV or AIDS
- ❑ Headache
- ❑ Other (please specify):

_____

_____

FAMILY MEDICAL HISTORY (*select all that apply and indicate which relative*)

- ❑ Cancer _____
- ❑ Rheumatic fever _____
- ❑ Heart disease_____
- ❑ Tuberculosis_____
- ❑ High blood pressure _____
- ❑ Seizures _____
- ❑ Hepatitis_____
- ❑ Diabetes _____
- ❑ Emotional disorders _____
- ❑ Other conditions (*specify*) _____

_____

LIFESTYLE (*select all that apply and indicate frequency)*

- ❑ Coffee _____
- ❑ Black tea _____
- ❑ Caffeinated beverages_____
- ❑ Alcohol_____
- ❑ Tobacco _____
- ❑ Recreational drugs _____
- ❑ Exercise _____

Allergies, Hospitalization, Injuries, Autoimmune Disease	
Allergies?	❑ No ❑ Yes (*specify*)
Psychiatric treatment?	❑ No ❑ Yes (*specify*)
Cardiac pacemaker?	❑ No ❑ Yes (*specify*)
Hospitalized in the past year?	❑ No ❑ Yes (*specify*)
Major surgeries?	❑ No ❑ Yes (*specify*)
Date of last physical exam	

GENERAL HEALTH AND WELL-BEING		
❑ Poor appetite	❑ Poor balance	❑ Fevers
❑ Large appetite	❑ Poor coordination	❑ Sweats easily
❑ Strong thirst	❑ Night sweats	❑ Fatigue
❑ Food cravings	❑ Insomnia	❑ Sudden energy loss
❑ Weight loss	❑ Disturbed sleep	❑ Anemia
❑ Weight gain	❑ Bruise or bleed easily	❑ Other _____
❑ Cold feet and hands	❑ Catch colds easily	
❑ Tremors	❑ Chills	

SKIN AND HAIR		
❑ Rashes	❑ Hair loss	❑ Neurodermatitis
❑ Ulcerations	❑ Recent moles	❑ Warts
❑ Psoriasis	❑ Dandruff	❑ Shingles
❑ Acne	❑ Eczema	❑ Other _____
❑ Itching	❑ Hives	
❑ Redness	❑ Dry skin	

HEAD, EYES, EARS, NOSE, AND THROAT		
❑ Dizziness	❑ Night blindness	❑ Change in smell
❑ Headaches	❑ Dry eyes or redness	❑ Sore throat
❑ Migraines	❑ Glaucoma	❑ Hoarseness
❑ Facial pain or numbness	❑ Cataracts	❑ Difficulty swallowing
❑ Trigeminal neuralgia	❑ Tinnitus	❑ Change in taste
❑ Bell's Palsy	❑ Decreased hearing	❑ Oral ulcers
❑ TMJ or jaw clicking	❑ Ear infection	❑ Toothache
❑ Floaters	❑ Nosebleeds	❑ Bleeding gums
❑ Eye pain	❑ Sinusitis	❑ Other _____
❑ Blurred vision	❑ Hay fever / allergies	

CARDIOVASCULAR		
❑ Palpitations	❑ Poor circulation	❑ Blood clots
❑ Irregular heart beat	❑ High blood pressure	❑ Other _____
❑ Coronary heart disease	❑ Low blood pressure	
❑ Chest pain / tightness	❑ Swelling of hands / feet	

RESPIRATORY		
❑ Chronic cough	❑ Difficulty breathing	❑ Frequent/chronic colds
❑ Coughing blood	❑ Difficulty breathing when lying down	❑ Bronchitis
❑ Coughing phlegm		❑ Flu
❑ Nasal congestion	❑ Pneumonia	❑ Other _____
❑ Shortness of breath	❑ Asthma	

GASTROINTESTINAL		
❑ Nausea	❑ Chronic gastritis	❑ Hemorrhoids
❑ Vomiting	❑ Ulcers	❑ Bad breath
❑ Diarrhea	❑ Indigestion	❑ Frequent laxative use
❑ Constipation	❑ Heartburn or acid reflux	❑ Gallstones
❑ Gas	❑ Lack of appetite	❑ Jaundice
❑ Bloating	❑ Excessive hunger	❑ Cirrhosis
❑ Belching	❑ Rectal pain	❑ Other _____
❑ Abdominal pain / Cramps	❑ Bloody or black stools	

UROGENITAL		
❑ Frequent urination	❑ Waking at night to urinate	❑ Kidney stones
❑ Painful urination	❑ Incontinence	❑ Genital sores
❑ Urgent urination	❑ Bladder infection	❑ Other (please specify):
❑ Decrease in urine flow	❑ Blood in urine	❑ Other _____
❑ Increase in urine flow	❑ Impotence	

MUSCULOSKELETAL		
❑ Neck pain	❑ Finger pain	❑ Chronic lumbar strain
❑ Back pain	❑ Leg cramps	❑ Sprained ankle
❑ Knee pain	❑ Rib pain	❑ Sciatica
❑ Foot or ankle pain	❑ Cervical spondylopathy	❑ Muscle weakness
❑ Shoulder pain	❑ Carpal tunnel syndrome	❑ Scoliosis
❑ Hip pain	❑ Tennis elbow	❑ Other _____
❑ Hand or wrist pain	❑ Acute lumbar sprain	

NEUROPSYCHOLOGICAL		
❑ Seizures	❑ Concussion	❑ Insomnia
❑ Epilepsy	❑ Depression	❑ Stroke or TIA
❑ Dizziness	❑ Anxiety	❑ Hemiplegia
❑ Loss of balance	❑ Bad temper	❑ Alcoholism
❑ Numbness	❑ Stress	❑ Schizophrenia
❑ Poor memory	❑ Attempted suicide	❑ Other _____
❑ Lack of coordination	❑ History of psychiatric treatment	

METABOLISM, ENDOCRINE, AND IMMUNE		
❑ Diabetes	❑ Simple obesity	❑ Chronic fatigue syndrome
❑ Gout	❑ Rheumatic arthritis	❑ Other _____
❑ High cholesterol	❑ Arthritis	
❑ Hyperthyroidism	❑ Lupus	
❑ Hypothyroidism	❑ Fibromyalgia	

MALE REPRODUCTIVE SYSTEM AND GENITALIA		
❑ Pain or itching of genitalia	❑ Lumps in testicles	❑ Enlarged prostate or prostatitis
❑ Genital lesions or discharge	❑ Impotence	❑ Other _____

FEMALE REPRODUCTIVE SYSTEM AND GYNECOLOGICAL		
❑ Painful menses	❑ Pelvic inflammatory disease	❑ Hot flashes
❑ No menses	❑ Abnormal pap smear	❑ Decreased sex drive
❑ Scanty menstrual flow	❑ Fibroids	❑ Vulvodynia
❑ Irregular menses	❑ Breast lumps or swelling	❑ Vomiting during pregnancy
❑ Premenstrual syndrome	❑ Endometriosis	❑ Infertility
❑ Menstrual odor	❑ Ovarian Cysts	❑ Polycystic ovarian syndrome
❑ Vaginal discharge	❑ STD	❑ Other _____
❑ Vaginal dryness	❑ Urinary tract infection	

AGE AT	(First period) (Menopause)	# Days	(Period flow) (Length of cycle)
COLOR	❑ Brown ❑ Light red/pink ❑ Dark red ❑ Bright red	QUANTITY ❑ Heavy ❑ Moderate ❑ Light CLOTS ❑ Big ❑ Small ❑ None	
PMS SYMPTOMS			
# PREGNANCIES	# LIVE BIRTHS	# MISCARRIAGES OR ABORTIONS	
CURRENTLY SEXUALLY ACTIVE ❑ Yes ❑ No		CONTRACEPTION (*if any)*	
RELEVANT PREGNANCY HISTORY			