MD Acupuncture & Herbal Medicine

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Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Social Security Number: ___ ___ ___ -- ___ ___ -- ___ ___ ___ ___ Occupation: _____

Date of Birth: _____ Sex: M F Marital Status: Married Single Divorced Other

Address: _____ City: _____ State: _____ ZIP: __ __ __ __ __

Telephone Home: _____ Cell: _____ Work: _____

Email Address: _____

Who is your primary health care provider? _____ Phone: _____

In an emergency, notify: _____

Phone: _____ Relationship: _____

Insurance Information

Primary Insurance Company Name: _____

Policy Number: _____ Group Nr: _____

Insurance Address: _____

Insurance Telephone Number: _____ Co-pay: _____

Name of Insured: _____ SSN: ___ ___ ___ -- ___ ___ -- ___ ___ ___ ___

Date of Birth: _____ Sex: M F Relation: _____

Secondary Insurance Company Name (if any): _____

Policy Number: _____ Group Nr: _____

Insurance Address: _____

Insurance Telephone Number: _____

Name of Insured: _____ SSN: ___ ___ ___ -- ___ ___ -- ___ ___ ___ ___

Date of Birth: _____ Sex: M F Relation: _____

Doctors in this office have my permission to keep my signature on file. I understand that the practice of acupuncture and herbal therapy are not an exact science and that there is no method to accurately predict the healing capabilities in each patient following treatment. My submission to acupuncture and herbal therapy implies my consent to the treatment given. I agree to assume full responsibility for all the treatment rendered, and to pay fees incurred by the office (including 50% attorney's fees) to pursue payment of delinquent accounts. I also authorize the release of any information necessary to process claims.

Signature: _____ Date: _____

How did you find out about our clinic? Dr's referral Yellow Pages Internet Other: _____

Welcome to MD Acupuncture & Herbal Medicine

Name: _____ Age: _____

DOB: _____ Sex: M F SSN: ___ ___ ___ -- ___ ___ -- ___ ___ ___

Consent Form

I, the undersigned, consent to the diagnosis and treatment of my health condition(s) by the doctors and practitioners of MD Acupuncture & Herbal Medicine clinic. I understand that treatment may include but not limited to: Acupuncture (disposable needles only), laser acupuncture, electric stimulation, mineral heat lamp, gua sha, cupping, acupressure, tui na, therapeutic massage, moxa, auriculotherapy, bleeding, Chinese herbal therapy (raw and pill form), diet and nutritional counseling.

I understand the associated sensations related to the different types of treatment, and that slight bruising from needles, cupping or gua sha is a normal side effect. I fully understand the potential risks of treatment could include the following: burns from a mineral heat lamp, bruising, puncturing organs, in the abdomen or chest cavities, shock induced by needle stimulation, premature labor in pregnant females, herbal side effects, drug interactions or allergic reactions. I also understand that I have the choice to accept or reject the proposed treatment.

I agree that I will inform the practitioner, before beginning any treatment, if any of the following apply to me: Pace maker, heart diseases, metal plates or rods in my body, have an infectious disease, have mental/emotional problems, am taking herbs or any drugs, am pregnant or suspect that I am pregnant.

I understand that Traditional Chinese Medicine (TCM) may affect people on many different levels: physical, mental, emotional, and spiritual because it works within the entire body to restore balance. I understand that the duration of treatment varies from person to person depending on the specific illness and body constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or series of treatments, and I do not hold MD Acupuncture & Herbal Medicine clinic responsible for any risks that may come about due to treatment. I agree that I will not hold MD Acupuncture and Herbal Medicine clinic responsible for any unintentional harm incurred during the treatment process. .

I have completed the patient information form completely and accurately, and understand and accept the risks involved in treatment.

I further understand that payment or insurance policy information is due at the time of treatment; that there will be a $25.00 fee for checks that are returned for non-sufficient funds; and that 12-hour notice is required for cancellation of appointments. MD Acupuncture & Herbal Medicine clinic reserves the right to change full price for any missed appointments without prior 12-hour notification.

_____ _____

Signature of Patient (Parent or Guardian if under 18) Date

Primary Reason for visiting MD Acupuncture & Herbal Medicine

Main problem you would like us to help you with? _____

_____

How long ago did this problem begin? _____

Have you been given a diagnosis for this problem? If so, what? _____

What kinds of treatment have you tried? _____

Have they helped alleviate the condition or problem? _____

Are you currently receiving treatment for your problem? _____

If yes, please describe: _____

_____

Personal Medical History

Significant Ilnesses			
☐ Cancer	☐ Seizures	☐ Diabetes	☐ Rheumatic Fever
☐ Hepatitis	☐ Heart Disease	☐ Thyroid Disease	☐ Stroke
☐ HIV (AIDS)	☐ Weight Problem	☐ Sexually Transmitted Diseases	☐ Mental illness
☐ Allergies	☐ Tuberculosis	☐ Addictive Disorders	☐ _____
☐ Asthma	☐ Herpes	☐ High Blood Pressure	☐ _____

Surgeries: _____

_____

_____

Significant Trauma (i.e. motor vehicle accidents, falls, etc.): _____

_____

_____

Have you ever received psychiatric treatment? _____

_____

Have you ever considered or attempted suicide? _____

_____

Any nervous habits? _____

_____

Any other problems you would like us to be aware of? _____

_____

Medicines: Include prescription, over the counter drugs, vitamins, herbs, etc. taken within the last three month.

_____

_____

_____

Average or typical blood pressure: _____ / _____ Averages pulse rate: _____

Allergies: _____

_____

Personal birth history (prolonged labor, forceps, Caesarean, etc.):

Childhood health: _____ Location: of upbringing: _____

Current emotional health: _____ Current quality of life: _____

Current relationship quality: _____ Current predominant emotion: _____

Occupation: _____ Stress level: _____

Have you had any unusual stresses recently? _____

Personal Medical History (continued)

Favorite time of year? _____ Worst: _____
Hobbies and recreational habits: _____
Do you have a regular exercise program? _____ Please describe: _____
Have you traveled abroad in the past year? _____ Where? _____

Recent Medical Experience within the last 3 month

Please check any of the following boxes if the condition occurred within the last 3 months

General (within the last 3 month)			
☐ Poor Appetite	☐ Localized Weakness	☐ Peculiar Tastes or Smells	☐ Sweat Easily
☐ Fevers	☐ Insomnia	☐ Bleeding	☐ Change in Appetite
☐ Fatigue	☐ Strong Thirst	☐ Weight Loss	☐ Night Sweats
☐ Tremors	☐ Poor Balance	☐ Weight Gain	☐ Depression
☐ Cravings	☐ Chills	☐ Joint Pain	☐ Emotional Changes
☐ Headaches	☐ Sudden Energy Drop	☐ Hearing Loss	☐ Bruising Easily

Skin and Hair *(within the last 3 month)*			
☐ Rashes	☐ Itching	☐ Change in Skin Texture	☐ Ulcers
☐ Eczema	☐ Hair Loss	☐ Dandruff	☐ Acne
☐ Recent *Moles*	☐ Change in Hair Texture	☐ Hives	☐ Psoriasis

Ear, Nose, Throat, Head and Eyes *(within the last 3 month)*				
☐ Dizziness	☐ Eye Pain	☐ Earaches	☐ Migraine	☐ Recurrent Sore Throat
☐ Ringing in Ears	☐ Glasses	☐ Glaucoma	☐ Eye Strain	☐ Sores on Lips
☐ Gum Problems	☐ Sinus Problems	☐ Poor Vision	☐ Grinding of Teeth	☐ Mouth Ulcers
☐ Night Blindness	☐ Headaches	☐ Cataracts	☐ Floaters in Eyes	☐ Toothache
☐ Facial Pain	☐ Blurred Vision	☐ Concussions	☐ Spots in Front of Eyes	☐ _____
☐ Color Blindness	☐ Jaw Click	☐ Poor Hearing	☐ Nose Bleeds	☐ _____

Respiratory *(within the last 3 month)*				
☐ Cough	☐ Coughing Blood	☐ Phlegm	☐ Shortness of Breath	☐ Painful Breathing
☐ Wheezing	☐ Bronchitis	☐ Asthma	☐ Easily Winded	☐ _____

Cardiovascular *(within the last 3 month)*			
☐ Blood Clots	☐ Fainting	☐ Cold Hands or Feet	☐ Low Blood Pressure
☐ Phlebitis	☐ Dizziness	☐ Swelling of Hands	☐ Shortness of Breath
☐ Chest Pain	☐ Swelling of Feet	☐ Irregular Heartbeat	☐ Difficulty Breathing
☐ Cold Sweats	☐ Palpitations	☐ High Blood Pressure	☐ _____

Gastrointestinal *(within the last 3 month)*			
☐ Nausea	☐ Bloating	☐ Blood in Stool	☐ Abdominal Pain
☐ Belching	☐ Constipation	☐ Black Stool	☐ Vomiting
☐ Diarrhea	☐ Hemorrhoids	☐ Bad Breath	☐ Gastric Ulcers
☐ Indigestion	☐ Parasites	☐ Intestinal Gas	☐ _____

Genitourinary *(within the last 3 month)*			
☐ Painful Urination	☐ Urgent Urination	☐ Scanty Urination	☐ Frequent Urination
☐ Blood in Urine	☐ Impotence	☐ Unable to Hold Urine	☐ Frequent Night Urination
☐ Genital Sores	☐ Kidney Stones	☐ Discolored Urine	☐

Recent Medical Experience (within the last 3 month) Continued

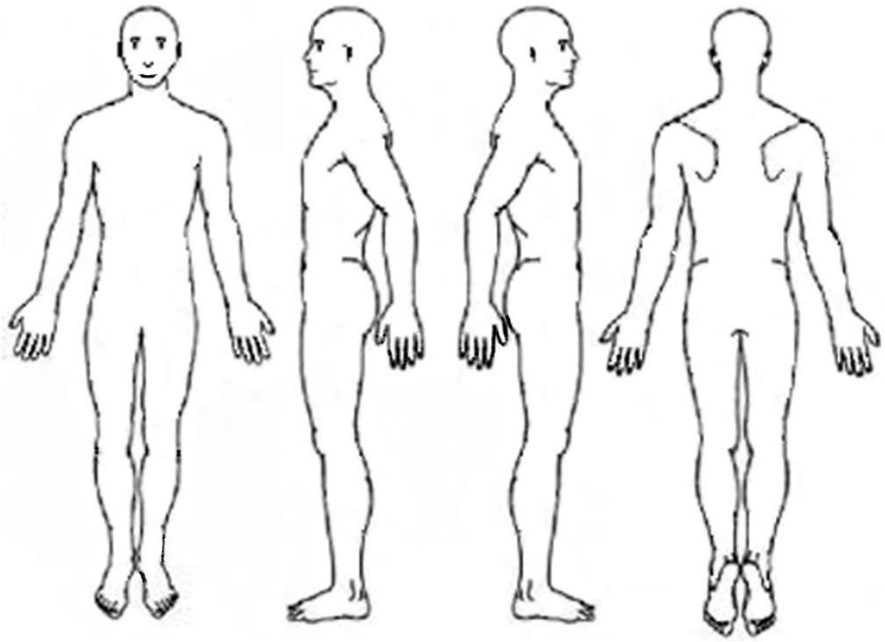
Please check any of the following boxes if the condition occurred within the last 3 months

Gynecology & Pregnancy *(Female only, within the last 3 month))*			
☐ Irregular Period	☐ Duration of Flow _____	☐ Nr of Pregnancies _____	☐ Nr of Difficult Births ___
☐ Clots	☐ Painful Periods	☐ Nr of Births _____	☐ Fertility Problems
☐ Light Flow	☐ Age of First Menses	☐ Nr of Miscarriages _____	☐ Breast Lumps
☐ Heavy Flow	☐ Date of Last Menses	☐ Nr of Abortions _____	☐ Vaginal Discharge
☐ PMS	☐ Last PAP	☐ Nr of Premature Births ___	☐ Vaginal Sores

Neuropsychological *(within the last 3 month)*			
☐ Seizures	☐ Areas of Numbness	☐ Concussion	☐ Loss of Balance
☐ Dizziness	☐ Lack of Orientation	☐ Depression	☐ Mood Swings
☐ Stress	☐ Poor Memory	☐ Anxiety	☐ Irritable
☐ Disorientation	☐ Migraines	☐ Easily Angered	☐ Headache

Musculoskeletal *(within the last 3 month)*				
☐ Neck Pain	☐ Back Pain	☐ Joint Pain	☐ Muscle Spasms	☐ Hand/Wrist Pain
☐ Scoliosis	☐ Shoulder Pain	☐ Knee Pain	☐ Muscle Cramping	☐ _____
☐ Hip Pain	☐ Arthritis	☐ Muscle Weakness	☐ Muscle Soreness	☐ _____
☐ Recent Sprains	☐ Weak Joints	☐ Injuries	☐ Foot/Ankle Pain	☐ _____

Please circle areas of pain or injury.
Please be prepared to describe the type and severity of pain.



Family Medical History (General Health)

Mother's side: _____

Father's side: _____

Siblings: _____

If any of the above are deceased, what was the cause? _____