

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 charge 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

<i>Significant Illnesses</i>			
<input type="checkbox"/> Cancer	<input type="checkbox"/> Seizures	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> HIV (AIDS)	<input type="checkbox"/> Weight Problem	<input type="checkbox"/> Sexually Transmitted Diseases	<input type="checkbox"/> Mental illness
<input type="checkbox"/> Allergies	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Addictive Disorders	<input type="checkbox"/> _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Herpes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> _____

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)			
<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Localized Weakness	<input type="checkbox"/> Peculiar Tastes or Smells	<input type="checkbox"/> Sweat Easily
<input type="checkbox"/> Fevers	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Change in Appetite
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Strong Thirst	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Night Sweats
<input type="checkbox"/> Tremors	<input type="checkbox"/> Poor Balance	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Depression
<input type="checkbox"/> Cravings	<input type="checkbox"/> Chills	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Emotional Changes
<input type="checkbox"/> Headaches	<input type="checkbox"/> Sudden Energy Drop	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Bruising Easily

Skin and Hair (within the last 3 month)			
<input type="checkbox"/> Rashes	<input type="checkbox"/> Itching	<input type="checkbox"/> Change in Skin Texture	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Eczema	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Acne
<input type="checkbox"/> Recent <i>Moles</i>	<input type="checkbox"/> Change in Hair Texture	<input type="checkbox"/> Hives	<input type="checkbox"/> Psoriasis

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

Respiratory (within the last 3 month)				
<input type="checkbox"/> Cough	<input type="checkbox"/> Coughing Blood	<input type="checkbox"/> Phlegm	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Painful Breathing
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> _____

Cardiovascular (within the last 3 month)			
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Fainting	<input type="checkbox"/> Cold Hands or Feet	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Swelling of Hands	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Swelling of Feet	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Cold Sweats	<input type="checkbox"/> Palpitations	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> _____

Gastrointestinal (within the last 3 month)			
<input type="checkbox"/> Nausea	<input type="checkbox"/> Bloating	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Belching	<input type="checkbox"/> Constipation	<input type="checkbox"/> Black Stool	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Gastric Ulcers
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Parasites	<input type="checkbox"/> Intestinal Gas	<input type="checkbox"/> _____

Genitourinary (within the last 3 month)			
<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Urgent Urination	<input type="checkbox"/> Scanty Urination	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Impotence	<input type="checkbox"/> Unable to Hold Urine	<input type="checkbox"/> Frequent Night Urination
<input type="checkbox"/> Genital Sores	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Discolored Urine	<input type="checkbox"/> _____

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

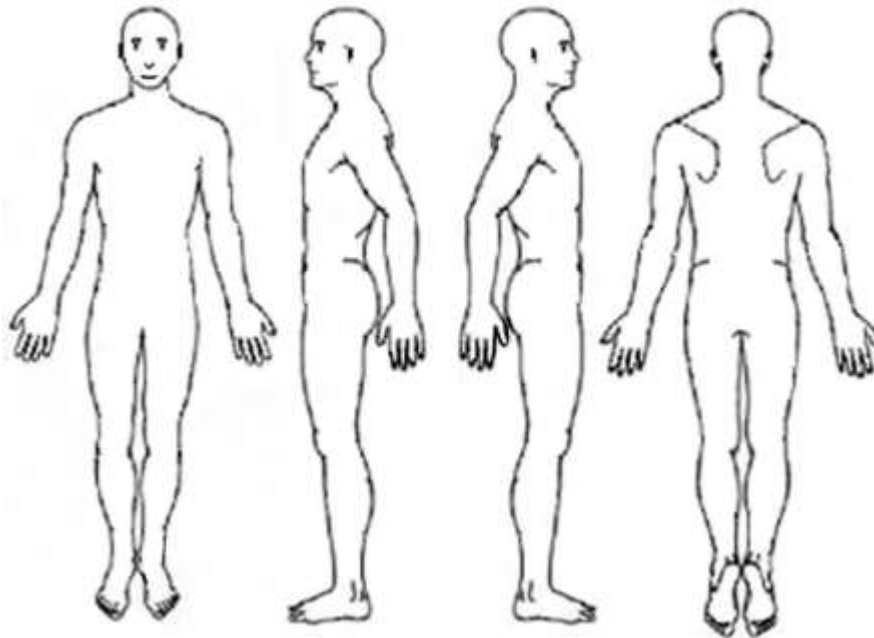
Gynecology & Pregnancy (Female only, within the last 3 month))			
<input type="checkbox"/> Irregular Period	<input type="checkbox"/> Duration of Flow _____	<input type="checkbox"/> Nr of Pregnancies _____	<input type="checkbox"/> Nr of Difficult Births ____
<input type="checkbox"/> Clots	<input type="checkbox"/> Painful Periods	<input type="checkbox"/> Nr of Births _____	<input type="checkbox"/> Fertility Problems
<input type="checkbox"/> Light Flow	<input type="checkbox"/> Age of First Menses	<input type="checkbox"/> Nr of Miscarriages _____	<input type="checkbox"/> Breast Lumps
<input type="checkbox"/> Heavy Flow	<input type="checkbox"/> Date of Last Menses	<input type="checkbox"/> Nr of Abortions _____	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> PMS	<input type="checkbox"/> Last PAP	<input type="checkbox"/> Nr of Premature Births ____	<input type="checkbox"/> Vaginal Sores

Neuropsychological (within the last 3 month)			
<input type="checkbox"/> Seizures	<input type="checkbox"/> Areas of Numbness	<input type="checkbox"/> Concussion	<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Lack of Orientation	<input type="checkbox"/> Depression	<input type="checkbox"/> Mood Swings
<input type="checkbox"/> Stress	<input type="checkbox"/> Poor Memory	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Irritable
<input type="checkbox"/> Disorientation	<input type="checkbox"/> Migraines	<input type="checkbox"/> Easily Angered	<input type="checkbox"/> Headache

Musculoskeletal (within the last 3 month)				
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Muscle Spasms	<input type="checkbox"/> Hand/Wrist Pain
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> Knee Pain	<input type="checkbox"/> Muscle Cramping	<input type="checkbox"/> _____
<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Muscle Soreness	<input type="checkbox"/> _____
<input type="checkbox"/> Recent Sprains	<input type="checkbox"/> Weak Joints	<input type="checkbox"/> Injuries	<input type="checkbox"/> Foot/Ankle Pain	<input type="checkbox"/> _____

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? _____