Patient Information

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire. All your information will be confidential. If you have questions, please ask. Thank you.

Patient Name:_____Today's Date____/____/_____

Gender:_____ Age:_____DOB:___/___/___ Referred by_____

Address_____City_____State___Zip_____

Home Phone: (___)_____Cell Phone: (___)_____ Occupation_____

In emergency notify_____Phone #_____

Marital Status: ___Single ___Married ___Divorced ___Widowed ___Minor

If Minor, Responsible Party_____

Employer's Name_____

Emploer's Address_____City_____State___Zip_____

Physician:_____ Physician Phone:_____

Chiropractor:_____ Phone #:_____

Do you have Health Insurance? Y/N, Name of Insurance Company:_____

Does your insurance cover acupuncture? Y/N

Have you ever been treated by acupuncture? Y/N

Insurance Information

In the event that insurance providers will pay for acupuncture, I am requesting this information. Please fill out as much as you are comfortable with. If your insurance will pay for acupuncture, I will assist in any way possible to obtain reimbursement.

Were you injured? Y/N Date of Injury_____ Auto/Work Comp/ Other (Circle)
Insurance Company:_____ Policy Holder:_____
Address:_____
Phone #:_____Group #:_____Claim #:_____
Attorney:_____Phone #:_____

*****Please provide a copy of the front and back of your Insurance Card*****

I hereby authorize my insurance company, including private medical insurance and any other health plan to pay benefits to which I am entitled for services by Xiaofei Shangguan, L.Ac, O.M and her associates. This will remain in effect until revoked by me in writing. I understand that I am responsible for all charges whether or not they are paid by said insurance. I authorize the use of this signature on all insurance submissions. I authorize, Xiaofei Shangguan L.Ac, O.M. and her associates, to release any information to secure payment of benefits. I also authorize the release of medical records and other pertinent information to my referring physician or any other medical personnel involved with the prescribed treatment initiated on this date.

I, _____, have read and fully understand the above policy.

Signature of Patient or Parent (if minor) _____ Date_____

Informed Consent to Oriental Medical Health Care

I hereby request and consent to the performance of the following on myself (or the patient named below for whom I am legally responsible) by **Xiaofei Shangguan L.Ac., O.M and her associates**, who now or in the future treats me: acupuncture and other oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual therapy such as bodywork, manipulation or joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation, cupping and/or moxibustion; dietary recommendations; exercise advice and healthy lifestyle counseling.

I understand I have an opportunity to discuss the nature and purpose of acupuncture and oriental medical procedures. Although I am aware that acupuncture and other procedures used in oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in allopathic medicine in the practice of oriental medicine, there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: slight bleeding, bruising, pain or other strong sensation at the location where a needle is inserted or radiating from that location, nerve pain, minor burns, aggravation or current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and stroke. I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment at Acupuncture Wellness Center.

_____	_____
Patient's Name (please print)	Patient's Signature Date
_____	_____
Print Name of Patient's Representative (if applicable)	Relationship to Patient
_____	_____
Signature of Patient's Representative (if applicable)	Date Signed

HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that the "Notice of Privacy Practices" has been provided to me. I understand I have a right to review their "Notice of Privacy Practices" prior to signing this document.

Members of the staff may need to contact you with appointment reminders or information related to your treatment. If this contact is made by phone, and you are not at home, a message will be left on your answering machine or with whoever answers the phone. Thank you cards, appointment reminders, birthday cards, holiday cards and other correspondence may be sent to your address. By signing this form you are giving us authorization to contact you with these reminders and information.

_____ _____

Patient Name Printed Date

_____

Patient Signature

Authorization for Release of Health Information (Optional)

I,_____, hereby authorize, Xiaofei Shangguan L.Ac., O.M. and her associates the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive my information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_____ _____

_____ _____

_____ _____

_____ _____

Patient Signature **Date**

Patient Intake Form

Patient Name:_____Age:_____Date of Birth:___/___/___

Main problem(s): You would like treated_____

When did this problem begin?_____

What are the possible causes of current issue(s)?_____

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

To what extent does this problem interfere with your daily activities (work, sleep, etc.)?

_____

What kind of treatment(s) have you tried?_____

What makes this problem worse?_____

What makes it better?_____

Is there anybody in your family with the same/similar problem?_____

Recent Medical Tests or Procedures (please indicate test results and dates below)

□ Physical □ Cholesterol □ Prostate Exam □ Blood Test

□ HIV/STD □ Pap Smear □ Mammogram □ Other

Test Results and Date:_____

Past Medical History: (Please include month/year when the diagnose was established)

Significant illness: □ Cancer □ Diabetes □ Hepatitis □ Thyroid Dz □ Seizures

□ Fibromyalgia □ Arthritis □ TB □ Anemia □ Hypertension

□ Breathing Problems □ Heart Dz □ Digestive Disorder □ HIV/AIDS Positive

□ Veneral Dz □ Other (please specify):_____

Surgeries_____ Hospitalization_____

Significant trauma_____

Allergies_____

Family Medical History (Please specify family member)

□ Hypertension □ Heart Dz □ Stroke □ Asthma □ Alcoholism □ Cancer

□ Miscarriage □ Diabetes □ Other

Medicines: Taken within the last two months (Including vitamins, over the counter drugs, herbs, etc.)

_____

Occupation

Do you usually work □ indoors □ outdoors ?

Any occupational stress (chemical, physical, psychological, etc.)_____

Personal

Height_____ Weight now_____ one year ago_____ Weight maximum at year_____

Habits

Do you smoke? Y/N What?_____ How many per day?_____ Since when?_____

If you are a smoker, do you want to quit? Y/N [Level of determination to quit- 1 2 3 4 5 6 7 8 9 10]

Please describe any use of drugs for non-medical purposes_____

Do you exercise regularly? Y/N Please describe your exercise program_____

How many hours do you sleep in general?_____When do you usually go to bed?_____

Diet

How much coffee do you drink?_____cups/day; Colas_____#/day; Tea_____cups/day_____

What kind of alcoholic beverages do you usually drink?_____ Average # of drinks/week_____

How much water do you drink per day?_____cups/day

Are you a vegetarian? □ Yes □ No □ Yes, but not so strict Do you eat a lot of spicy food? Y/N

Remarks and additional information (e.g. diet)_____

Please describe your average daily diet (Please be as specific as possible):

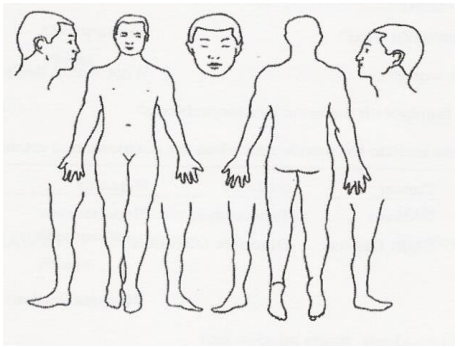
Morning_____

Afternoon_____

Evening_____

Snacks_____

Indicate painful or distressed area:



Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General

□ Poor appetite □ Poor sleeping □ Fatigue □ Fevers □ Chills

□ Night sweats □Sweat easily □Tremors □ Cravings □ Change in appetite

□ Poor balance □ Bleed or bruise easily □ Localized weakness □ Weightloss □ Weight gain

□ Peculiar tastes □ Desire for spicy food □ Desire cold foods □ Strong thirst (cold or hot drinks)

□ Sudden energy drop (what time of day)_____

Favorite time of year_____Worst time of year_____

Skin & Hair

□ Rashes □ Ulceration □ Hives □ Itching □ Eczema □ Pimples □ Dandruff

□ Dry skin □ Recent Moles □ Loss of Hair □ Change of hair or skin textures □ Other:

Musculoskeletal

□ Joint disorders □ Muscle weakness □ Pain/soreness in the muscles □ Tremors

□ Difficulty walking □ Cold hands/feet □ Swelling of hands/feet □ Back pain

□ Spinal curvature □ Hernia □ Numbness □ Tingling

□ Paralysis □ Neck tightness □ Neck pain □ Shoulder pain

□ Hand/wrist pain □ Hip pain □ Knee pain □ Sprain of joint

□ Other:

Head, Eyes, Ears, Nose and Throat

□ Dizziness □ Concussions □ Migraines

□ Glasses/lens □ Eye strain □ Eye pain □ Color blindness □ Night blindness

□ Poor vision □ Cataracts □ Blurry vision □ Spots in front of eyes

□ Earaches □ Ringing in ears □ Poor hearing □ Sinus problems □ Nose bleeding

□ Sore throat □ Grinding teeth □ Teeth problems □ Sores on lips/tongue □ Facial pains

□ Jaw clicks □ Difficulty swallowing □ Other:

Cardiovascular

□ High blood pressure □ Low blood pressure □ Chest pain □ Palpitation □ Fainting

□ Rapid heartbeat □ Irregular heartbeat □ Phlebitis □ Varicose veins □ Other:

Respiratory/LU

□ Persistent cough □ Coughing blood □ Wheezing □ Difficulty breathing □ Bronchitis

□ Nosebleeds □ Sinus congestion □ Sore throat □ Chronic allergies □ Asthma

□ Dry skin □ Hives □ Eczema □ Grief □ Emphysema

□ Pneumonia □ Chest pain □ Production of phlegm – What color?_____

Allergies to: □ Mold □ Cedar □ Dust □ Pet Fur □ Oak □ Hay Fever □ Grass □ Environmentally sensitive

Gastrointestinal/SP-ST

□ Bloating □ Cravings □ Acid Reflux □ Fatigue after meals

□ Nausea □ Vomiting □ Diarrhea □ Constipation □ Gas □ Belching

□ Indigestion □ Black stools □ Blood in stools □ Bad breath □ Rectal pain □ Hemorrhoids

□ Abdominal pain/cramps □ Gallbladder problems □ Parasites □ Chronic laxative use

Bowel movements: Frequency_____ Color_____ Odor_____ Texture/form_____

Accumulated Damp

□ Foggy mind □ Swollen hands/feet □ Edema in the legs □ Edema in the abdomen

□ Joint stiffiness/ache □ Symptoms worsen in rainy weather

□ Heaviness of the head, the limbs, or of the whole body

Neuro-psychological

□ Loss of balance □ Lack of coordination □ Concussion □ Depression □ Anxiety □ Stress

□ Bad temper □ Bi-polar

Genito-urinary

□ Pain on urination □ Frequent urination □ Blood in urine □ Urgent to urinate □ Kidney stones

□ Unable to hold urine □ Dribbling □ Pause of flow □ Frequent urinary tract infection

□ Pain in genitals □ Itching of genitals □ Strong odor □ Other:

Female

□ Frequent vaginal infections □ Pelvic infection □ Endometriosis □ Fibroids □ Clots

□ Vaginal/genital discharge □ Ovarian cysts □ Breast tenderness □ Breast lumps

□ Irregular periods □ Pain/cramps prior/during periods □ Hot flashes

□ Moodiness related to periods □ Fertility problems ___# of pregnancies ___# of births ___Miscarriages

___Abortions ___Premature births ___Cesareans ___Difficult delivery

First day of last period_____ Age of first menses___ Duration of periods _____days, cycle_____days

Do you practice birth control? Y/N. If yes, what type and for how long?_____

If you are on birth control pills, what are you taking and for how long?_____

_____

Male

□ Prostate problems □ Discharge □ Impotence □ Frequent seminal emission

□ Fertility problems □ Ejaculation problems □ Painful/swollen testicles □ Other

Both □ Normal □ High sex drive □ Diminished sex drive □ Infertility □ Fatigue following sex

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I understand the above information and guarantee this form was completed correctly to the best of my knowledge.

Signature:

□ Adult Patient □ Parent or Guardian □ Spouse

For Patient Review Regarding Diagnostic Exam
Please sign one of the two options listed below:

Option 1:

I have received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition which I am seeking treatment.

Patient Signature Date

Option 2:

I have NOT received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition which I am seeking treatment. Ohio law requires that a Licensed Acupuncturist recommend that you receive a diagnostic examination from a physician or chiropractor regarding the condition for which you are seeking treatment.

I understand this recommendation.

_____

Patient Signature Date

Licensed Acupuncturist Signature Date

CC: Patient file
Provided to patient