ACUPUNCTURE & CHINESE MEDICINE CLINIC

Notification Form Regarding Evaluation of Patient by Physician

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

Full name		Sex ☐F ☐M	Date	
DOB	Age	Occupation	SSN	
E-mail	Home phone	Work phone		
Address: Street		City	State	Zip
In Emergency, notify		Marital status ☐S ☐M ☐D ☐W # of children:		
Family physician		Chiropractor		
Do you have health insurance? ☐Y ☐N		Insurance Company		
Does your insurance cover acupuncture? ☐Y ☐N		Have you ever been treated by acupuncture before? ☐Y ☐N		
How did you know this clinic? ☐ Referral _____ ☐Periodicals ☐Direct mail ☐Location or walk-by ☐Website ☐Yellow pages ☐Other (Please specify) _____				

Main problem(s):

You would like us to help you with _____

When did this problem begin? _____

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

_____

What kinds of treatment have you tried? _____

What makes this problem worse? _____

What makes this problem better?_ _____

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

_____

Past medical history: (Please include the month/year when the diagnosis was established)

Significant illness	Cancer	Diabetes	Hepatitis	Thyroid disease	Seizures
Fibromialgia	Arthritis	Tuberculosis	Hypertension	Emotional imbalance	Anemia
Breathing problems	Heart disease	Digestive disorders	HIV/AIDS Positive	Venereal Disease	
Other (please specify)					

Surgeries: **Hospitalization:**

Significant trauma: (auto accidents, sports injuries, etc)

Allergies: (drugs, chemicals, foods)

Family medical history: (Please specify family member)

Cancer	Diabetes	Hepatitis	Hypertension	Heart disease	Stroke
Asthma	Alcoholism	Miscarriage	Other (please specify)		

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages)

_____

Occupation:

Do you usually work ☐ indoors ☐ outdoors ?

Occupational stress (chemical, physical, physiological, etc) _____

Personal:

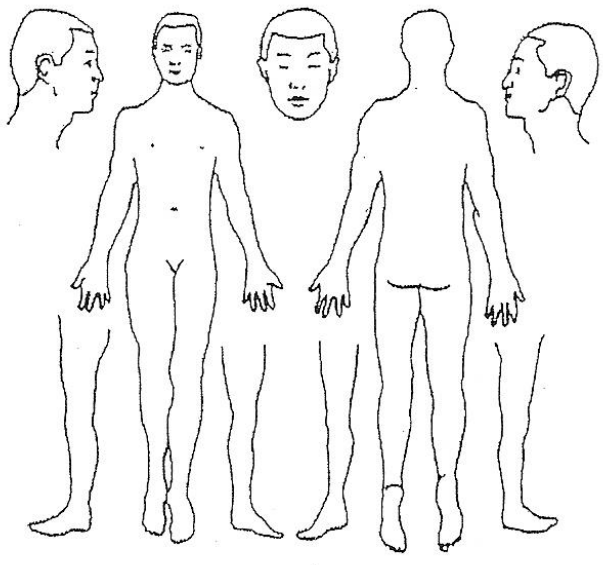
Height _____ Current weight _____ Weight one year ago _____

Maximum weight _____ in year _____

Habits:

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

Indicate painful or distressed areas:



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 ☐ Tremors ☐ Cravings ☐ Weight loss ☐ Weight gain
☐ Strong thirst (hot or cold drinks)

Skin & hair ☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching ☐ Eczema
☐ Pimples ☐ Dandruff ☐ Dry skin ☐ Recent moles ☐ Hair loss

Musculoskeletal ☐ Joint disorders ☐ Weak muscles ☐ Pain/soreness in muscles ☐ Tremors
☐ Difficulty walking ☐ Cold hands/feet ☐ Swelling of hands/feet
☐ Numbness ☐ Tingling ☐ Paralysis ☐ Neck tightness ☐ Neck pain ☐ Shoulder pain
☐ Back pain ☐ Spinal curvature ☐ Hernia ☐ Knee pain ☐ Sprain of joint
☐ Hand/wrist pain ☐ Hip pain

Head, eyes, ears, nose and throat ☐ Dizziness ☐ Migraines ☐ Eye strain ☐ Eye pain
☐ Color blindness ☐ Night blindness ☐ Poor vision ☐ Cataracts ☐ Blurry vision ☐ Earaches
☐ Ringing in ears ☐ Poor hearing ☐ Spots in front of eyes ☐ Sinus problems ☐ Sore throat
☐ Grinding teeth ☐ Teeth problems ☐ Facial pain ☐ Sores on lips/ tongue
☐ Difficulty swallowing

Cardiovascular ☐ High blood pressure ☐ Chest pain ☐ Palpitation ☐ Fainting
☐ Irregular heartbeat ☐ Rapid heartbeat ☐ Varicose veins

Respiratory ☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Difficulty breathing
☐ Bronchitis ☐ Pneumonia ☐ Chest pain ☐ Production of phlegm – What color? _____

Gastrointestinal ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Belching
☐ Black stools ☐ Blood in stools ☐ Indigestion ☐ Bad breath ☐ Hemorrhoids ☐ Parasites

☐ Abdominal pain/ cramps ☐ Gallbladder problems ☐ Chronic laxative use

Bowel movements: Frequency _____

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

☐ Urgency to urinate ☐ Kidney stones ☐ Inability to hold urine ☐ Dribbling

☐ Pause of flow ☐ Frequent urinary tract infection ☐ Pain in genital ☐ Itching of genital

☐Other

Female ☐ Frequent vaginal infections ☐ Pelvic infection ☐ Endometriosis ☐ Fibroids

☐ Vaginal discharge ☐ Ovarian cysts ☐ Irregular periods

☐ Clots ☐ Pain/cramps prior to/during periods ☐ Breast tenderness ☐ Breast lumps ☐ Hot flashes

☐ Fertility Problems ☐ Moodiness related to periods

___ number of pregnancies ___ number of births ___ miscarriages ___ abortions

___ premature births ___ Cesareans ___ Difficult delivery

First date 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? _____

Male ☐ Prostate problems ☐ Discharge ☐ Impotence ☐ Frequent seminal emission

☐ Fertility problems ☐ Ejaculation problems ☐ Painful/ swollen testicles

☐ Other

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

Signature: ☐Adult patient ☐ Parent of Guardian ☐ Spouse

Notification Form Regarding Evaluation of Patient by Physician

Pursuant to the requirement of section 183.7 (e) of this title and section 6.11, Subsection (d) V. A. C. S. article 4495b, governing the practice of acupuncture)

I _____ (patient's name) am notifying the Acupuncture & Chinese Medicine Clinic of following:

Yes ___ No ___ I have been evaluated by a physician or dentist for the condition being treated within twelve (12) months before the acupuncture was performed. I recognize that a physician or dentist should evaluate me for the condition being treated by the acupuncturist. _____ (patient's initials)
Date: _____

Yes ___ No ___ I have received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is _____, and the most recent date of chiropractic treat prior to acupuncture treatment is _____. After being referred by a chiropractor, if after 60 days or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to physician. It is my responsibility and choice to follow this advice.

_____

Patient Signature (required) Date

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for one of the following conditions:

___ Chronic Pain
___ Weight Loss
___ Smoking Cessation

_____

Patient Signature (required) Date

The Acupuncture & Chinese Medicine Clinic is not responsible for untrue statements made by patient.

Request and consent

I hereby request Shuangzhu Qin L.Ac. to treat me. I also authorize her to perform on me the treatment known as Acupuncture as her judgment may indicate and authorize her to use whatever therapeutic methods she may see fit. Whether or not such methods are commonly and generally accepted and practiced in this community.

Shuangzhu Qin has frankly and fully explained to me the nature and purpose of the treatment, the risks involved, including but not limited to mild bruise from needling, possible burns from moxibustion. In giving my consent to the treatment, I have in mind her frank and full explanation. If any unforeseen condition arises in the course of treatment and in the judgment of the Acupuncturist it is advisable to use procedures in addition to or different from those now contemplated, I also request and authorize her to do whatever she deems advisable.

If you are suffering from any of the following diseases/conditions, please notify the acupuncturist at this time:

1. **Heart condition**
2. **Diabetes**
3. **Fainting from needles**
4. **Bruise easily**
5. **Stroke**
6. **Please confirm that the acupuncturist has shown you the disposable needles. Yes**

In the event that my condition is such that treatment is beyond the normal capabilities of the acupuncturist. I understand that I may be referred to other competent practitioners including, but not necessarily limited to, medical physicians or other acupuncturist.

I also agree to give 24 hours notice if I am going to be unable to make my scheduled appointment. I fully understand I will be charged the regular fee if I miss an appointment without giving 24 hours notice.

_____ _____

Date Signature of Patient