PATIENT INFORMATION FORM

Name:_____ **Phone Home:**_____ **Work:**_____
Address: _____ **City:** _____ **State:**____ **Zip:**_____
Birth date:_____ **Age:**_____ **Male/Female:**____ **Emergency No:**_____
Occupation:_____ **Physician:**_____ **Ht:**_____ **Wt:**_____
Referred by:_____ **Email:**_____ **SSN:**_____
Main Problem:_____**Onset:**_____
Other Concurrent Therapies:_____

Past Medical History – include dates

Significant Illnesses: ___Cancer ___Diabetes ___High Blood Pressure ___Heart Disease
___Hepatitis ___Rheumatic Fever ___Thyroid Disease ___Seizures ___Other:_____

Surgeries:_____

Significant Trauma:(*auto accidents/falls etc*)_____

***Birth History*:**(*prolonged labor, forceps delivery etc*)_____

Allergies:(*drugs, chemicals, foods*)_____

Medicines: *(taken within the last two months, include vitamins, over-the-counter drugs, herbs etc*)
_____

Occupational Stresses:(*chemical, physical, psychological etc*)_____

Exercise:_____

Comments:_____

Average Daily Diet:
Morning:_____
Noon:_____
Evening:_____

Habits: ___Cigarettes ___Coffee ___Tea ___Cola ___Alcohol ___Drugs ___Sugar ___Salt ___Other:_____

Family Medical History: ___Diabetes ___Cancer ___High Blood Pressure ___Heart Disease ___Stroke
___Seizures ___Asthma ___Allergies ___Alcoholism ___Other:_____

Notes:_____
_____

GENERAL

___ Poor appetite	___ Heavy appetite	___ Poor sleep	___ Heavy sleep
___ Insomnia	___ Fatigue	___ Tremors	___ Vertigo
___ Cold hands	___ Cold feet	___ Cold back	___ Cold abdomen
___ Fevers	___ Chills	___ Night sweats	___ Sweat easily
___ Cravings	___ Localized weakness	___ Poor coordination	___ Change in appetite

___ Sudden energy drop (*at time*) _____ ___ Peculiar tastes/smells _____
___ Strong thirst (*cold/hot drinks*)_____ ___ Bleed/bruise easily (*where*) _____

Notes:_____
_____

SKIN AND HAIR

___ Rashes	___ Ulcerations	___ Hives	___ Itching
___ Eczema	___ Pimples	___ Dandruff	___ Loss of hair
___ Change in hair/skin texture	___ Purpura	___ Other hair or skin problems:_____	

_____
_____

HEAD, EYES, EARS, NOSE AND THROAT

___ Dizziness ___ Concussions ___ Migraines ___ Glasses
___ Eye strain ___ Eye pain ___ Poor vision ___ Night blindness
___ Color blindness ___ Cataracts ___ Blurry vision ___ Earaches
___ Ringing in ears ___ Poor hearing ___ Nose bleeds ___ Sinus problems
___ Mucus ___ Dry throat ___ Dry mouth ___ Copius saliva
___ Teeth problems ___ Jaw clicks ___ Grinding teeth ___ Facial pain
___ Gum problems ___ Spots in eyes ___ Recurrent sore throats-months_____
___ Sores on lips or tongue ___ Headaches (where and when)_____
___ Other head or neck problems:_____

CARDIOVASCULAR

___ High blood pressure ___ Low blood pressure ___ Chest pain ___ Irregular heartbeat
___ Dizziness ___ Swelling in hands/feet ___ Cold hands/feet ___ Fainting
___ Blood clots ___ Phlebitis ___ Difficulty breathing ___ Other
_____

RESPIRATORY

___ Cough ___ Coughing blood ___ Asthma ___ Bronchitis
___ Pneumonia ___ Difficulty breathing when lying down ___ Tight chest
___ Production of phlegm-what color:_____

GASTROINTESTINAL

___ Nausea ___ Vomiting ___ Diarrhea **Bowel Movement:**
___ Gas ___ Belching ___ Black stools ___ frequency_____
___ Bad breath ___ Rectal pain ___ Hemorrhoids ___ color_____
___ Constipation ___ Bloody stools ___ Sensitive abdomen ___ odor _____
___ Pain or cramps ___ Laxative use: _____ /week; type:_____ ___ texture/form_____

GENITO-URINARY

___ Pain on urination ___ Frequent urination ___ Blood in urine ___ Urgency to urinate

___ Unable to hold urine ___ Kidney stones ___ Venereal disease ___ Impotency
___ Wake up to urinate-How often _____/night; time:_____

PREGNANCY AND GYNECOLOGY

___ Number pregnancies ___ Number births ___ Premature births ___ Miscarriages
___ Age at first menses ___ Period (days) ___ Duration ___ Irregular periods
___ Flow (describe) ___ Clots Last PAP:_____ Last menses:_____
___ Vaginal discharge ___ Vaginal sores ___ Beast lumps Menopause:_____
___ Birth control-type and duration:_____ ___ changes in body/psyche prior to menstruation
_____

MUSCULOSKELETAL

___ Neck pain ___ Muscle pains ___ Back pain (where) ___ Joint pain (where)
___ Other joint or bone problems?_____

NEUROPSYCHOLOGICAL

___ Seizures ___ Areas of numbness ___ Poor memory ___ Concussion
___ Depression ___ Anxiety ___ Bad temper ___ Easily stressed
___ Treated for emotional problems ___ Other neurological or psychological problems:

Dr. Qinghong HAN, AP
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Phone: 941-363-7968

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and CCOUNTABILITY ACT OF 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

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This Consent was signed by: _____

Printed name (Patient or Representative) _____

Date:_____/_____/_____

Witnessed by:_____ (Printed name – Practice representative)

Date:_____/_____/_____

STATEMENT OF FINANCIAL POLICY

- **FULL PAYMENT IS DUE AT THE TIME OF SERVICE**. We accept cash, check, and credit card.
- If you have insurance coverage, co-pay and deductible are due at the time of service. If your insurance denies the payment, you are responsible for the full payment of the service.
- There is a $40 fee for a returned check; 100% collection fee will be added to the regular rate in case the debt collection process is necessary.
- Kindly give us 24 hours' notice if you need to cancel an appointment.
- Our policy is to charge the normal treatment rate for a missed appointment.
- Your treatment will be more effective if you follow the guidelines of your doctor and stick to your treatment schedule.

Patient signature (authorizes treatment):_____

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INFORMATION CONSENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient names below for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working for or associated with or serving s backup for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (oriental massage), oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to orally provided instructions provided. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinic staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near medical sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes major risks of treatment, other side effects and risk may occur. The herbs and nutritional supplements considered safe in practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known as in my best interests. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits or 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 condition and for my future condition(s) for which I seek treatment.

Signature of Patient:_____Date____/_____/____