Golden Mean Acupuncture

PATIENT INFORMATION AND MEDICAL HEALTH HISTORY

General Information

NAME _____ DATE _____

ADDRESS _____

CITY _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

E-MAIL ADDRESS _____

BIRTH DATE _____ AGE _____ GENDER_____ MARITAL STATUS _____

Emergency Information

CONTACT NAME _____ RELATIONSHIP_____

CONTACT'S PHONE NUMBER_____

PRIMARY CARE PROVIDER NAME _____

CITY _____ PHONE NUMBER (if known) _____

TYPE OF CARE _____

SECONDARY CARE PHYSICIAN'S NAME

_____

CITY _____ PHONE NUMBER (if known) _____

TYPE OF CARE _____

Cancellation Policy

All appointments require that all scheduled appointments be given at least 24 hours notice of cancellation. Failure to provide 24-hour notice may be subject to full charge of the standard session fee.

Initials of Participant or Guardian: _____

MEDICAL HISTORY QUESTIONNAIRE

CHECK ALL CURRENT AND PAST CONDITIONS.
(please write the word PAST next to those conditions which you have had only in the past and are no longer present)

HEAD AND NECK:
____ Dizziness
____ Fainting
____ Neck Stiffness
____ Enlarged lymph glands
____ Headaches
_____ Other

EARS:
____ Infection
____ Ringing
____ Decreased hearing
_____ Other

EYES:
____ Blurred vision
____ Visual changes
____ Poor night vision
____ Spots/Floaters
____ Eye inflammation/Styes
_____ Other

NOSE, THROAT & MOUTH:
____ Bleeding
____ Sinus infection
____ Hay fever or allergies
____ Sore throat
____ Hoarseness
____ Changes in taste
____ Difficulty swallowing
____ Changes in smell
____ Oral ulcers/Canker sores
_____ Other

SKIN:
____ Hives
____ Rashes
____ Eczema
____ Psoriasis
____ Seborrhea
____ Night sweating
____ Excess sweating
____ Dryness
____ Bruises easily
____ Changes in moles or lumps
_____ Other

NEUROLOGICAL:
____ Numbness or tingling of limbs
____ Seizures
____ Tremors
____ Pain
____ Paralysis
____ Epilepsy or Convulsions
_____ Other

INFECTION HISTORY:
____ HIV/AIDS, or HIV risks: Self or partner
____ TB: Self or household
____ Hepatitis, or Hepatitis risk: Self or partner.
____ History of sexually transmitted diseases: Self or partner.
____ Gonorrhea
____ Chlamydia
____ Syphilis
____ Genital warts
____ Herpes (oral)
____ Herpes (genital)
____ MRSA, Staph, CRE, or other Drug-Resistant Infections

RESPIRATORY:
____ Chronic cough
____ Coughing up blood
____ Coughing phlegm frequently
____ Difficulty breathing
____ Wheezing/Asthma
____ Frequent Colds
____ Emphysema
____ Pneumonia repeatedly
_____Other

CARDIOVASCULAR:
____ Palpitations
____ Chest pain or tightness
____ Rapid heart beat
____ Irregular heart beat
____ Heart Disease
____ Poor circulation
____ Swelling of ankles
____ Phlebitis
____ Cold hands/feet
____ Cardiac Pacemaker
____ High blood pressure
____ Stroke
_____ Other

GASTROINTESTINAL:
____ Indigestion
____ Nausea
____ Stomach pain
____ Irritable bowel disease
____ Colitis
____ Crohn's Disease
____ Pancreatitis
____ Celiac Disease
____ Recent change in bowel habits
____ Diarrhea (___ /day)
____ Constipation (___ /week)
____ Dry, hard stools
____ Soft, difficult, sticky stools
____ Irregularly or poorly-formed stools
____ Poor appetite
____ Excessive hunger
____ Blood in stool or black stools
____ Hemorrhoids
____ --with pain or blood
____ Gall bladder disorder
____ Vomiting blood
____ Peptic Ulcer
____ Recent change in weight
____ Food cravings
_____ Other

MUSCLES AND JOINTS:
____ Joint disorder
____ Sore muscles
____ Weak muscles
____ Difficulty walking
____ Spinal curvature
____ Backache
____ Back pain
____ Fibromyalgia
_____ Other

MALE:
____ Pain/itching of genitalia
____ Genital lesions/discharge
____ Impotence
____ Premature ejaculation
____ Prostate problems
____ Infertility (e.g., abnormal sperm)
_____ Other

FEMALE:
____ Frequent vaginal infections
____ Infertility
____ Pain/itching of genitalia
____ Genital lesions/discharge
____ Pelvic inflammatory disease
____ Abnormal Pap smear
____ Irregular periods
____ Emotional changes with menses
____ Clots with menses
____ Painful menstrual periods/cramps
____ Premenstrual Syndrome
____ Abnormal bleeding
____ Menopausal symptoms (hot flashes, etc.)
____ Breast lumps/cysts
____ Breast swelling and/or pain
_____ Other

URINARY:
____ Frequent urinary tract/bladder infections
____ Weak urinary stream
____ Recent change in bladder habits
____ Kidney Disease
____ Frequent day urination (___ X)
____ Frequent night urination (___ X)
_____ Other

GENERAL:
____ Fatigue
____ Thirst
____ Aversion to cold
____ Insomnia
____ Frequent dreams/nightmares
____ Depression
____ Agitation
____ Irritability
____ Anxiety
____ History of psychiatric treatment
____ Poor memory
____ Difficulty concentrating
____ Sores that don't heal
____ Congenital abnormalities
____ Surgical implants
____ Unusual bleeding or discharge
____ Jaundice
____ Hernia
____ Epstein Barr virus (EBV)
____ Rheumatic Fever
____ Diabetes mellitus
____ Thyroid Disorder
____ Cancer
____ Anemia or other blood disorder
____ Lupus erythematosis
_____ Other

TO BE COMPLETED BY PATIENT: **Name:** _____ **Date:** _____

MEDICAL HISTORY QUESTIONNAIRE

Please complete the following as accurately as possible.

Patient Name: _____ Date: _____

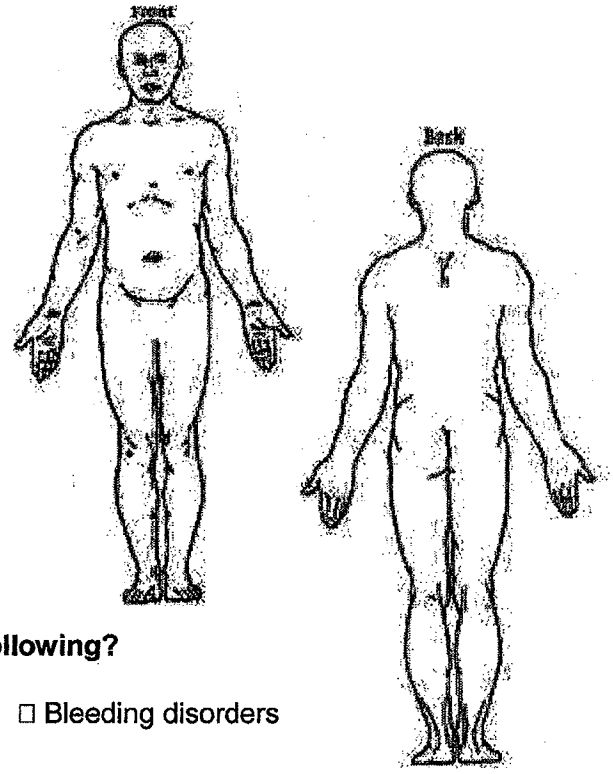
Present Illness:

What is your chief complaint?

When did this condition begin?

What treatment have you received already?

Mark below with an X where you feel pain or discomfort.



Medical History:

What surgeries have you had? When did you have them?

What other serious injuries or illnesses have you had?

Do you have any allergies that you know of?

What medications are you taking?

Which, if any, of your blood relatives have had any of the following?

☐ Stroke ☐ Cancer ☐ Heart Disease ☐ Tuberculosis ☐ Bleeding disorders
☐ Diabetes ☐ High blood pressure

Please List Your Primary Physician's Name and Contact Information:

Name:_____ Phone: _____
Address:_____
Specialty, if any: _____

Occupation or profession_____ Employer _____

Menstrual History:

Age of your first period: _____
Vaginal discharge: _____
Length of cycle, day 1 to day 1: _____
Length of flow (days): _____
Date of your last period: _____
Do you believe you are pregnant? Yes____ No____
Number of pregnancies: _____
Number of live births: _____

Recreational Substance Usage:

History of smoking? _____
how many years? _____
how many per day? _____
History of smokeless tobacco use? _____
History of drinking alcohol? _____
how many drinks/week? _____
History of recreational drug use? _____
How many cups of coffee/day? _____
How many sodas/day? _____

Medications and Supplements

Please list all medications, supplements, vitamins and minerals that you take regularly as well as the reason why you are taking them.

Date:	Medication/ Supplement:	Reason:	Dose and How often:		Date of last dose:	Prescribed by:	Start date:

ACUPUNCTURE INFORMED CONSENT TO TREAT

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 named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up 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 (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical 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 the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese 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 the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my 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 of 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 any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Golden Mean Acupuncture, Inc. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO) when applicable. Please refer to, Golden Mean Acupuncture, Inc.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Golden Mean Acupuncture, Inc. reserves the right to revise its Notice of Privacy Practices at any time.

With my consent, Golden Mean Acupuncture, Inc. may call my home or any other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Golden Mean Acupuncture, Inc. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

With my consent, Golden Mean Acupuncture, Inc. may email to me appointment reminders and patient statements. I have the right to request that Golden Mean Acupuncture, Inc. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Golden Mean Acupuncture, Inc. to use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Golden Mean Acupuncture, Inc. may decline to provide treatment to me.

PATIENT CONSENT

DATE: _____ _____

Signature of Consenting Party

TIME (AM/PM)_____ _____

Print Name

IF CONSENTING PARTY IS OTHER THAN PATIENT

_____ _____

Signature of Consenting Party Signature of Witness

_____ _____

Print Name *Print Name*

OFFICE POLICY SUMMARY

Welcome to Golden Mean Acupuncture. We want you to be comfortable and to receive the best care possible. Please do not hesitate to ask any questions you might have regarding your visit, your billing, or our policies.

FEES The fees charged in this office are comparable to those charged by other healthcare providers in this area, with similar qualifications. Please ask to see our fee schedule. We accept cash, credit cards, and personal checks. Please note there is a $25.00 charge for checks returned due to insufficient funds.

Initial_____

INSURANCE COVERAGE Many insurance policies cover Acupuncture, but we do not claim that yours does. Policies can differ greatly in terms of deductible and percentage of coverage for Acupuncture. We can verify coverage and submit your claim form for reimbursement, provided you sign financial agreement below.

Initial_____

RELEASE OF INFORMATION Your insurance company may require medical reports to document our treatment and progress. Your initials below authorize the release of medical information necessary to process your claim.

Initial_____

CANCELLATIONS As a courtesy to our office and other patients, we ask that you please notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment. You will be charged a $50.00 fee for any missed appointment or cancellation giving less than 24 hours notice.

Initial_____

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS

I, (print full name) _____, am receiving or about to receive health care services in this office. I understand that I am responsible to pay all non-insurance related fees when services are rendered, including herbs, etc. If I choose to use my insurance I understand I will be responsible for all “non covered” services and /or coinsurance/co-pays associated with my office visit. In addition I authorize insurance payment of medical benefits to Golden Mean Acupuncture

By signing below, I agree to comply with the office policies stated above which I have read and understood. I also authorize the use of this signature on all insurance submissions.

_____ _____

Patient Signature *Date*