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	Employer
E-mail		Phone Number:	
Address: Street		City	State Zip
Marital status ☐S ☐M ☐D ☐W # of children:			
Have you ever been treated by acupuncture before? ☐Y ☐N		How did you know this clinic?	
Insurance Company:		Insurance Phone#:	
Insurance ID #:		Does your insurance cover acupuncture? ☐Y ☐N	
Primary Insured Name:		Primary Insured DOB:	
Deductible:		Copay:	
Coinsurance:		# Visits/ Calendar Year:	

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?

_____

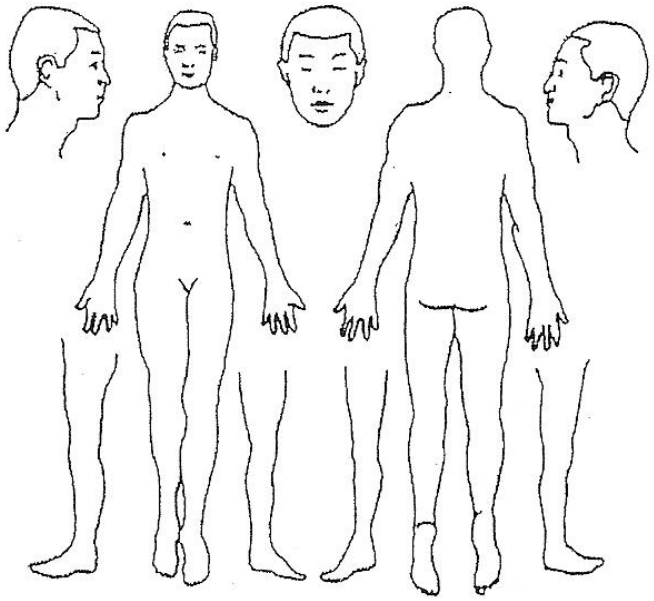
Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages)

_____

Habits:

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

Indicate painful or distressed areas:



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

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.

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