TIAN SHI ACUPUNCTURE

Caring for the Whole You

Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential.

PATIENT INFORMATION

Date
Name
Address
City State Zip
Birth Date Age Sex
Marital Status Occupation
Your Physician
Physician's Phone
How did you hear about our office?
Have you ever had acupuncture?

CONTACT INFORMATION

Home Phone
Work Phone
Cell Phone
E-mail
Emergency Contact:
Name
Relationship
Home Phone
Work Phone
Cell Phone

MEDICAL HISTORY

Reason for visit today
How long have you had this condition? Is it getting worse?
What seemed to be the initial cause?
Is your condition related to an auto accident or employment? If yes, is it still billable through insurance?
What seems to make your condition better?
What seems to make it worse?
What other treatments have you tried for this condition?
List medications/supplements taken in the last two months

FAMILY HISTORY *(please check any of the following that have occurred in your blood relatives)*

- ❑ Alcoholism
- ❑ Allergies
- ❑ Arteriosclerosis
- ❑ Asthma
- ❑ Cancer
- ❑ Diabetes
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Seizures
- ❑ Stroke
- ❑ Other _____

PAST MEDICAL HISTORY *(please check any conditions you have or have had in the past)*

- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Allergies
- ❑ Arteriosclerosis
- ❑ Asthma
- ❑ Birth Trauma
- ❑ Bleeding Disorders
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Surgery (list below)
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Goiter
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Major Trauma (car, fall, etc. [list below])
- ❑ Measles
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pleurisy
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatic Fever
- ❑ Tuberculosis
- ❑ Scarlet Fever
- ❑ Seizures
- ❑ Stroke
- ❑ Thyroid Disorders
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Whooping Cough
- ❑ Other (list below)

Details:

HEALTH HISTORY ***(please check any symptoms you currently have or have had in the past year)***

GENERAL SYMPTOMS

- ❑ Like cold drinks
- ❑ Like hot drinks
- ❑ Recent weight loss/gain
- ❑ Poor sleep
- ❑ Heavy sleep
- ❑ Dream-disturbed sleep
- ❑ Fatigue
- ❑ Lack of strength
- ❑ Bodily heaviness
- ❑ Cold hands or feet
- ❑ Poor circulation
- ❑ Peculiar taste (describe below)
- ❑ Chills
- ❑ Fever
- ❑ Aversion to cold
- ❑ Aversion to heat
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Vertigo/dizziness
- ❑ Muscle cramps
- ❑ Other _____

Details: _____

HEAD, EYES, EARS, NOSE, THROAT

- ❑ Headaches
- ❑ Migraines
- ❑ Eye strain
- ❑ Eye pain
- ❑ Red eyes
- ❑ Itchy eyes
- ❑ Spots in eyes
- ❑ Poor vision
- ❑ Blurred vision
- ❑ Teeth problems
- ❑ Grinding teeth
- ❑ TMJ
- ❑ Gum problems
- ❑ Dry mouth
- ❑ Sores on lips or tongue
- ❑ Excessive saliva
- ❑ Sinus problems
- ❑ Excessive phlegm (Color _____)
- ❑ Swollen glands
- ❑ Lumps in throat
- ❑ Recurrent sore throat
- ❑ Enlarged thyroid
- ❑ Nose bleeds
- ❑ Nasal discharge
- ❑ Nasal obstruction
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Earaches
- ❑ Ear discharge
- ❑ Concussion
- ❑ Other _____

Details: _____

SKIN/HAIR

- ❑ Dryness
- ❑ Hematomas
- ❑ Bruise easily
- ❑ Rashes
- ❑ Itchiness
- ❑ Psoriasis
- ❑ Eczema
- ❑ Acne
- ❑ Oily skin
- ❑ Jaundice
- ❑ Brittle hair/nails
- ❑ Dandruff
- ❑ Premature gray hair
- ❑ Hair loss
- ❑ Dry scalp
- ❑ Dark circles under eyes
- ❑ Bags under eyes
- ❑ Other _____

Details: _____

RESPIRATORY

- ❑ Asthma
- ❑ Cough (❑ Wet ❑ Dry)
- ❑ Coughing blood
- ❑ Pneumonia
- ❑ Phlegm/sputum
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Sneezing
- ❑ Snoring
- ❑ Tightness in chest
- ❑ Bronchitis
- ❑ Frequent colds
- ❑ Sensitivity to humidity
- ❑ Sensitivity to dryness
- ❑ Sensitivity to wind
- ❑ Sensitivity to heat
- ❑ Sensitivity to cold
- ❑ Other _____

Details: _____

CARDIOVASCULAR

- ❑ Low blood pressure
- ❑ High blood pressure
- ❑ Chest pain
- ❑ Tachycardia
- ❑ Blood clots
- ❑ Heart palpitations
- ❑ Irregular heartbeat
- ❑ Swelling of ankles
- ❑ Edema
- ❑ Varicose veins
- ❑ Other _____

Details: _____

GASTROINTESTINAL

- ❑ Nausea
- ❑ Vomiting
- ❑ Bloating
- ❑ Gas
- ❑ Hiccup
- ❑ Acid regurgitation
- ❑ Indigestion
- ❑ Stomachache
- ❑ Intestinal pain
- ❑ Diarrhea/loose stools
- ❑ Constipation
- ❑ Black stools
- ❑ Bloody stools
- ❑ Mucous in stools
- ❑ Hemorrhoid
- ❑ Other _____

Details: _____

MUSCULOSKELETAL

Pain, numbness, and/or weakness in:

❑ Arms	❑ Shoulders	❑ Ankles	❑ Middle back
❑ Elbows	❑ Legs	❑ Feet	❑ Lower back
❑ Wrists	❑ Hips	❑ Neck	❑ Joints
❑ Hands	❑ Knees	❑ Upper back	❑ Other _____

Details: _____

NEUROPSYCHOLOGICAL

❑ Paralysis	❑ Depression	❑ Easily stressed	❑ Fear
❑ Tremor	❑ Anxiety	❑ Feel angry	❑ Nervousness
❑ Seizures	❑ Irritability	❑ Feel sad	❑ Suicidal thoughts
❑ Poor memory	❑ Mood swings	❑ Forgetful	❑ Other _____
❑ Difficulty focusing/concentrating		❑ Mind not clear	

Details: _____

GENITO-URINARY

❑ Bed wetting	❑ Blood/pus in urine	❑ Decreased libido	❑ Frequent urination
❑ Inability to control urine	❑ Kidney infection/stones	❑ UTI	❑ Wake to urinate
❑ Other _____			

Details: _____

MEN ONLY

❑ Diminished libido	❑ Erection difficulties	❑ Genital pain	❑ Penis discharge
❑ Prostate problems	❑ STD	❑ Other _____	

Details: _____

WOMEN ONLY

❑ Currently pregnant	❑ Contraceptives	❑ Vaginal infections	❑ Vaginal prolapse
❑ May be pregnant	❑ Abnormal PAP	❑ Yeast infections	❑ Uterine prolapse
❑ Pregnancy(s)_____	❑ Menopausal symptoms	❑ STD	❑ Endometriosis
❑ Miscarriage(s)_____	❑ Diminished libido	❑ Other _____	

Menstruation:

Bleeding: ❑ Heavy ❑ Normal ❑ Light

Onset _____	Cycle length_____	Days of flow_____	Color _____
❑ Painful periods	❑ Clots in menses	❑ Bleed between periods	❑ Irregular periods
❑ Post menstrual pains	❑ PMS	❑ Mood swings	

Details: _____

DIET & LIFESTYLE *(List average daily menu)*

Morning	Snack	Noon	Snack	Evening	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

❑ Alcohol	❑ Tobacco	❑ Good appetite	❑ Occupational hazards
❑ Caffeine	❑ Artificial sweetener	❑ Poor appetite	❑ Exercise excessively
❑ Drugs	❑ Sugar	❑ Stress	❑ Exercise regularly
❑ Other _____			

Details: _____

Signature X_____ Date_____

INITIAL PATIENT CONDITION ASSESSMENT

Name_____ Date_____

Please specify major complaints, conditions, and/or symptoms:

1. _____
2. _____
3. _____

Symptom/Condition Rating

Please complete rating scales below for the categories that are affected by your condition(s).
RATING SCALE IS SUBJECTIVE: 0 = No Problem 10 = Worst

Pain/numbness	Irritability	Reproductive/Sexual	Job Productivity
Headache	Digestion	Exercise/Recreational	Anxiety
Fatigue	Urinary	Standing/Walking	Depression
Sleep	Bowel	Relationships	Overall Outlook

Frequency of symptom(s) and/or pain (day refers to a 24-hour period)

❑ Occasional	❑ Intermittent	❑ Frequent	❑ Constant
<25% of the day	<50% of the day	<75% of the day	Up to100% of the day

Please indicate the number of days per week you experience these symptoms and/or pain _____.
Please provide any further details or clarification on any of the above subjects/categories as deemed necessary:

_____

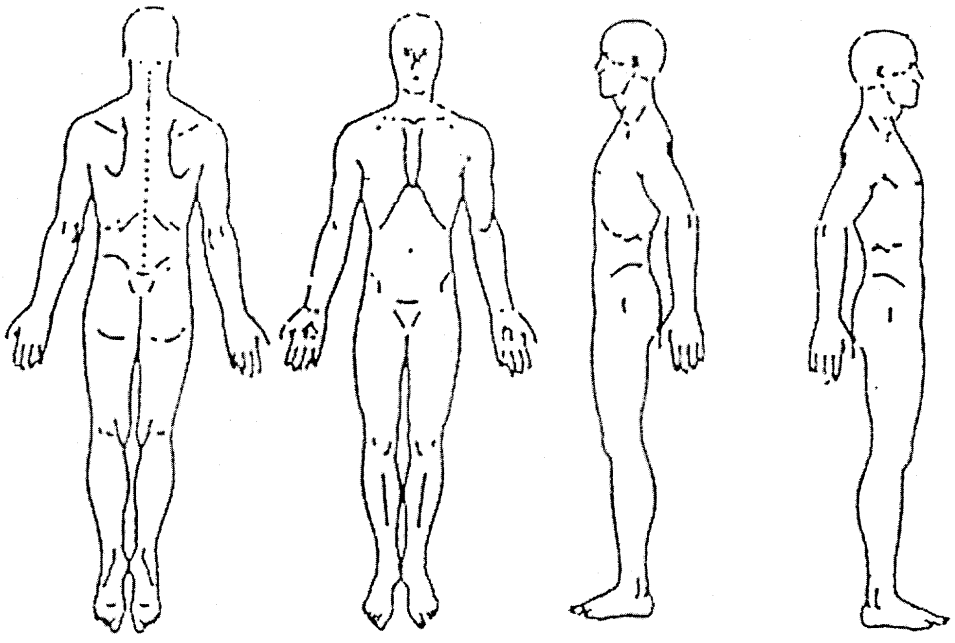
_____

_____

Pain Assessment Diagram

THIS PORTION WILL NEED TO BE COMPLETED AFTER PRINTING.

If pain is a component of your condition, please mark each painful area on the body images with a numbered 1-10 to indicate the severity of your pain (if applicable).



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Consent to Medical Treatment

I voluntarily consent to receive Acupuncture and/or Chinese Herbal Medicine treatment administered by Batbayar Damdin, Dipl. Ac., L.Ac. I understand his training is in Acupuncture and Oriental Medicine and that he is not, nor claims to be, a medical doctor. I understand that the practice of Traditional Chinese medicine is not an exact science and diagnosis and treatment may involve risk of injury. I acknowledge that no guarantee has been made to me as to the results of any examination or treatment by Batbayar Damdin, Dipl.Ac., L.Ac.

Initials _____

Financial Policy

The following is a statement of Tian Shi Acupuncture's Financial Policy. All patients must complete the Patient Intake and Office Policy forms before receiving treatment from Batbayar Damdin, Dipl. Ac., L.Ac. Full payment is due at the time of service for all office visits and procedures. No discounts for services or products will be allowed unless written and agreed upon by Batbayar Damdin. The terms of any applicable prepayment discounts, treatment packages, or third-party financing plans are available for review at our office. We accept cash, checks, and credit or debit cards. This office is not a participating provider with any insurance carrier. However, if your insurance carrier does cover your services, you may elect to forward your receipts of payment for reimbursement.

This office requests 24-hour notification of any change to or cancellation of an appointment. If no notice of appointment cancellation is provided, it is our policy to charge the missed visit at the normal office visit rate. If the appointment was purchased in a package, the missed appointment charge will be deducted from the remaining appointments in the package. This office recognizes that emergencies and extenuating circumstances arise and those will be considered on an individual basis.

Accounts are considered delinquent after 60 days. Interest will be charged accordingly to all past- due accounts. Any collection charges that are incurred on balances that are turned over to a collection agency or legal representative are the responsibility of the patient.

Initials _____

I have read and understand each of the sections contained above. I understand that by signing this document, I am agreeing to and providing the authorization/consent contained in each of the above sections where my initials or those of my representative are located. I have had the opportunity to ask questions regarding each of these sections and all such questions have been answered to my satisfaction.

X_____ _____ _____

Signature of Patient or Representative | Print Name | Date

_____

Relationship to Patient if Representative

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO OBTAIN, USE, AND DISCLOSE HEALTH INFORMATION

Notice of Privacy Practices
I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment. Prior to signing this acknowledgement and consent, I have had the opportunity to review the Notice of Privacy Practices in this organization's office or at www.tianshiacupuncture.com.

I understand that this information serves as:
- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:
- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

Request for restrictions
This organization will release information relating to my office appointments, directions for treatment or herbal supplements via telephone calls, answering machine messages, facsimile, or electronic mail. This organization may also communicate general information to you about the practice of acupuncture via newsletter using the name, address, and e-mail information you provided.

Please specify below any request to restrict the use, dissemination, or method of communication of your medical information as provided in the Notice of Privacy Practices, including notification to your primary care provider that you are receiving treatment at Tian Shi Acupuncture.

_____

_____

I hereby acknowledge that I have received and understand the Notice of Privacy Practices, consent to the use and disclosure of information as described therein, and release Batbayar Damdin, Dipl. Ac., L. Ac. and his employees from any legal responsibility or liability in connection with the disclosure of the information.

X_____ _____ _____

Signature of Patient or Representative | Print Name | Date