

Healing Art Acupuncture & Massage

PATIENT RECORD

Name _____ Birth Date _____ Sex _____
Last Name First Name

Home Address _____

City _____ State _____ Zip _____ SSN _____

Home Phone () _____ Cell Phone () _____

e-mail address: _____

Occupation: _____ Employer: _____

Work Address _____

City _____ State _____ Zip _____

Emergency Contact _____ Phone () _____

Spouse's Name _____ Referred By _____

Insurance: Co. _____ Phone () _____

Present Complaints _____

Please answer the following questions by circling the correct answer

Do you have a tendency to faint? Yes No	Are you HIV positive? Yes No
Do you have a pacemaker? Yes No	(Women) Are you pregnant? Yes No
Do you bleed for a long time? Yes No	What kind of medications are you on now? _____
Have you ever had Hepatitis? Yes No	_____

Our Office Policy

- | | |
|---|---|
| <p>1. We are a provider for BCBS-FL, and Aetna Ins. Patients must file their own claims directly.</p> <p>2. We do not bill insurance directly. Patients are expected to take care of their fees as services are rendered. We do not claim responsibility of collecting your insurance claim or for negotiating a settlement of a disputed claim.</p> <p>3. If you need to cancel your appointment, please inform us at least 24 hours prior to your appointment to avoid a full service charge. A missed appointment will be charged at full rates.</p> <p>4. There is a service charge of \$15.00 for every returned check from the bank.</p> | <p>5. I authorize the release of any medical records/other information necessary to process a claim with my insurance.</p> <p>6. If you are under 18 years of age, please have your parent or legal guardian sign below.</p> <p>7. Healing Art Acupuncture is required, by law, to maintain the privacy and confidentiality of your protected health information. The policy is available for you to read in our waiting room or you can also request a written copy. Please ask office staff for more information.</p> |
|---|---|

Signature of Insured or Parent

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Information Consent to Chinese Medicine Diagnosis and Therapy

Chinese Medicine is healing system that includes multiple therapeutic modalities. This medical system facilitates the body's innate healing capability and requires participation in taking personal responsibility in assisting one's own health recover. In some cases, symptoms may relapse or intensify temporarily during the course of treatment before relief is attained. The patient is a partner with the acupuncturist in the healing process. The statements below describe the treatment modalities, which may be employed during treatment and will assist understanding and participation in the healing process. _____ Initials ←

1. **Acupuncture** is a technique utilizing fine sterile disposable stainless steel needle inserted at specific points in the body to cause a positive response in order to connect various ailments. The location of the application of needle and the depth of their insertion is determined by the nature of the problem. I understand that the application of these needles may be accompanied by some painful sensation and that there is a slight possibility that a minor swelling, bleeding, discoloration, hematoma, fainting, or bruise may occur at the site of insertion. A sensation of momentary euphoria or light-headedness may occur after acupuncture treatment. I will immediately notify the acupuncturist if I experience any symptoms or problems. _____ Initials ←

2. **Electrical Stimulation** of the acupuncture needles involves using a small battery –powered stimulator attached by Electrodes to the ends of the needles. A slight throbbing or tingling sensation may be felt during the use of this stimulator. This modality is usually employed for pain management and other specific conditions. _____ Initials ←

3. **Moxibustion** is the application of indirect heat supplied by burning the herb *Folium Artemisiae Vulgaris* or commonly knows as “Mugwort plant” over a single or group of acupuncture points. The area of treatment may remain red and warm for several hours afterwards. In rare incidences a minor burn may occur at the site of moxibustion. If this incident occurs, I will immediately notify the acupuncturist if I experience any symptoms or problems. If I do not immediately notify the acupuncturist of any discomfort of any kind whatsoever or any type of reaction to the moxibustion treatment, then I assume any and all responsibility of any kind whatsoever as a result of aforementioned moxibustion treatment. _____ Initials ←

4. **Cupping** utilizes round suction cups over a large muscular area such as the back to enhance blood circulation to the designated area. This method may produce redness, discoloration, and on rare occasion a minor blister may form that may persist up to several days but will eventually disappear. _____ Initials ←

5. **Herbal Nutrients** are utilized to facilitate the body's own restorative process. These herbs are usually taken in powder form. Chinese herbal powder tends to taste bitter because they are made mostly from roots, barks, and different parts of a plant. On rare occasions, temporary gastric upset may occur. If any discomfort persists, accompanied by hives or shortness of breath, I will advise by attending acupuncturist immediately. _____ Initials ←

6. **Tuina** is a specialized bodywork technique or treatment. In facilitating healing and pain management. Occasionally there may be increase soreness or bruising at the sites of the treatment. _____ Initials ←

There are risks involved in any procedure or treatment. I do not expect the acupuncturist to be able to anticipate all risks and complications related to my condition, and I understand that acupuncture or Chinese Medicine cannot successfully treat all medical conditions. I understand that an acupuncturist is not a medical doctor. I desire to rely on the acupuncturist to exercise judgment during the course of treatment, which the acupuncturist deems appropriate and in my best interests, based upon the facts then known. I also understand that, whenever necessary, I must continue to seek treatment with a medical doctor for any conditions which cannot be resolved by acupuncture or Chinese Medicine _____ Initials ←

I hereby certify, by signing below, that I have read this entire form, asked questions if I did not understand and that I consent to the provisions described above. 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.

→ _____
Signature

_____ **Date**

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Patient Information Chart

NEUROPSYCHOLOGICAL

- | | | |
|--|---|--|
| <input type="checkbox"/> Stress | <input type="checkbox"/> Considered suicide | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Physically abused | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bad temper | <input type="checkbox"/> Emotionally abused | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Worry | <input type="checkbox"/> Sexually abused | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mania | <input type="checkbox"/> Lack of coordination |
| <input type="checkbox"/> Cry often | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Unfocused/confused thoughts |
| <input type="checkbox"/> Hospitalized for emotional issues | In therapy Yes NO | <input type="checkbox"/> Cancer (type) _____ |
- Do you feel you get adequate affection in your life?
- _____
- _____

Other: (accidents etc) _____

REPRODUCTIVE & GYNECOLOGICAL (Women only)

- | | | |
|---|--|---|
| _____ # of Pregnancies | _____ # of Births | _____ # of Miscarriages |
| <input type="checkbox"/> Long periods (7 days or more) | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Vaginal discharge (color & odor) |
| <input type="checkbox"/> Short periods (3 days or less) | <input type="checkbox"/> Clotting | <input type="checkbox"/> Yeast infections |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> PMS- breast distension | <input type="checkbox"/> Menopausal symptoms |
| <input type="checkbox"/> Painful ovulation | <input type="checkbox"/> PMS- emotional symptoms | <input type="checkbox"/> Birth control (what type?) _____ |
- Other: _____

**Please let your practitioner know if there is any chance you may be pregnant today.
Some acupuncture points and herbs are contraindicated during pregnancy.**

I, (patients's name), _____, am notifying the Acupuncturist, Tzong Jiunn Wu of the following:

I have been evaluated by a physician or dentist for the condition being treated within six (6) months before this acupuncture treatment was performed YES NO

I recognize that I *should* be evaluated by a physician for the condition being treated by the acupuncturist _____
Patient's initials

I have received a referral from my chiropractor within the last 30 days for acupuncture YES NO NA

After being referred by a chiropractor, after 30 days or 20 treatments, whichever comes first, if no substantial improvement occurs in the condition being treated, I understand that the Acupuncturist is required to refer me to a physician. It is my responsibility and *choice* whether to follow this advice.

→ _____
Signature of Patient _____
Date

Signature of Acupuncturist _____
Date

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PATIENT MEDICAL HISTORY

The following is a list of symptoms, which you may or may not have experienced:

No Mark= never experience > = Sometimes experience + = Frequently experience

CARDIOVASCULAR		RESPIRATORY		MALES ONLY	
Shortness of breath		Cough		Prostate Problems	
High Blood Pressure		Coughed up blood		Pain in Testicles	
Irregular Heart Beat		Sore Throats			
Heart Palpitations		Nasal Problems		FEMALES ONLY	
Dizziness		Nose Bleed			
Chest Pain or Pressure		Asthma or Wheezing		Pre-Menstrual Pain	
Leg Cramps		Pneumonia		Menstrual Pain	
		Hay fever		Irregular Menstrual Cycle	
		Bronchitis			
GASTROINTESTINAL		COPD		MISCELLANEOUS	
		TB			
Indigestion				Jaundice (Yellowish Skin)	
Abdominal Pain or cramps		GENITOURINARY		Hepatitis C	
Gall Stones				Hepatitis B	
Constipation		Kidney Stones		HIV	
Diarrhea		Frequent Urination		Memory Loss	
Blood in Bowel Movement		Painful Urination		Headaches	
Black Bowel Movement		Bloody Discharge		How frequent?	
Excess Appetite		Venereal Disease		Insomnia	
Decrease Appetite		Pain in Genital area		Fever	
Excess Thirst		Poor Bladder Control		Chills	
Loss of Thirst		Decrease Sex Drive		Night Sweats	
Nausea and Vomiting				Intolerance-Weather change	
Colitis or Diverticulitis		MUSCULO-SKELETAL			
Belching or Burping				OTHER	
Heartburn		Back Pain			
Difficulty Swallowing		Arthritis		Allergic to Alcohol	
		Muscle Pain or Cramps		Allergic to Medicines	
EYES and EARS		Painful Joints		Cancer type	
Macular Degeneration		SKIN		Please list:	
Blurred Vision		Ulcerations			
Sudden Hearing loss		Where?			
Hearing Loss due to accident		Psoriasis			
Jaundice (yellow eyes)		Xerosis			
Ringling in the ears		Hives			