# WEI'S CHINESE MEDICAL CENTER
## CONTACT INFORMATION

Today's Date: __ /___ /_____

First Name: _____ Last Name: _____
Sex: ☐ F ☐ M DOB___/____/_____ Age:_____ SSN:_____
Marital Status: ☐ M ☐ S ☐ D ☐ W
Address: _____

City: _____ State: _____ Zip: _____
Occupation:_____ Employer:_____

Telephone – Home: _____ Preferred: (circle: Home Cell Work)

Other: Work: _____ Cell: _____

Do we have your permission to send appointment reminders, health newsletters, and occasional promotions to your email address?

**Yes _____ No _____**

We will not sell or give your email to any other agency.

**Email Address: _____**

Emergency Contact:

Name: _____ Telephone: _____

Relationship: _____

How did you find out about us?

☐ Direct Mail ☐ Location or Walk By ☐ Friend/Relative ☐ Website ☐ Periodicals

☐ Yellow Pages ☐ Other

Referred By: _____

Primary Insurance Company:_____ ID #:_____
Group #:_____ Name of Insured:_____
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent
Customer Service Phone Number:_____

Secondary Insurance:_____ ID #:_____
Group #:_____ Name of Insured:_____
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent
Customer Service Phone Number:_____

**Chief Complaint:**_____
How long? _____ How often: _____
What caused this (accident, lifestyle, drug, etc.)?

_____
Describe the worst it can be:

_____
What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other?

_____
Get temporary relief? _____ Fixes your problem? _____Causes side effects? _____
Affect your family? _____Affect your sleep? _____
Affect your work? _____ Affect your hobbies? _____
What is your goal/plan if the problem continues 5/10/20 years?

_____

**Complaint #2:**_____
How long? _____ How often: _____
What caused this (accident, lifestyle, drug, etc.)?

_____
Describe the worst it can be:

_____
What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other?

_____
Get temporary relief? _____ Fixes your problem? _____Causes side effects? _____
Affect your family? _____Affect your sleep? _____
Affect your work? _____ Affect your hobbies? _____
What is your goal/plan if the problem continues 5/10/20 years?

_____

**Complaint #3:**_____
How long? _____ How often: _____
What caused this (accident, lifestyle, drug, etc.)?

_____
Describe the worst it can be:

_____
What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other?

_____
Get temporary relief? _____ Fixes your problem? _____Causes side effects? _____
Affect your family? _____Affect your sleep? _____
Affect your work? _____ Affect your hobbies? _____
What is your goal/plan if the problem continues 5/10/20 years?

_____

**Other Complaints:** _____

On a scale of 1-10, rate your commitment to get rid of the problem(s) and feel better_____
Have you had acupuncture before? _____
If yes, where/who _____
Any concerns or fears about the needles? _____
If yes, what? _____
What are your goals of your acupuncture visits?

1. _____
2. _____
3. _____

| **MEDICAL CONDITIONS** Please List conditions & surgeries you have had and year diagnosed. | | **ALLERGIES** Medications, Seasonal, Environmental, Food. |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**MEDICATIONS** – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops and nose sprays. NOTE: If need more space, use page 4.

| Prescription Name | Purpose | How Long | Dose | How Often | Last Dose |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**For each symptom you currently have, rate its severity from 1- 5 (5 being the worst).**
**LEAVE BLANK IF NOT APPLICABLE**

***LIVER / GALLBLADDER***

_____ Irritability / Anger
_____ Depression / Stress
_____ Headaches / Migraines
_____ Visual Problems
_____ Red / Dry / Itchy Eyes
_____ Gall Stones
_____ Dizziness
_____ Blurred Vision
_____ Feeling of Lump in Throat
_____ Clenching of Teeth at Night
_____ Muscle Cramping / Twitching
_____ Tension
_____ Joints/Neck/Shoulder
_____ Pain/Tight
_____ Poor Circulation
_____ Soft / Brittle Nails
_____ Emotional Eater

***KIDNEY / URINARY BLADDER***

_____ Urinary Problems
_____ Bladder Infection
_____ Lack of Bladder Control
_____ Weakness / Pain in Lower Back
_____ Decrease Bone Density
_____ Feel Cold Easily
_____ Low Sex Drive
_____ Excess Sexual Desire
_____ Poor Memory
_____ Loss of Hair
_____ Hearing Problems
_____ Cavities
_____ Craving / Avoiding Salty Foods
_____ Fear
_____ Hot Flush / Night Sweating

***HEART / SMALL INTESTINES***

_____ Heart Palpitations
_____ Chest Pain
_____ Insomnia / Sleep Problems
_____ Easily Startled
_____ Restlessness / Agitation
_____ Vivid Dreams
_____ Lack of Joy in Life

***LUNG / LARGE INTESTINE***

_____ Dry Cough
_____ Cough with Sputum
_____ Nasal Discharge
_____ Post-Nasal Drip
_____ Sinus Infection / Congestion
_____ Itchy, Red or Painful Throat
_____ Dry Mouth / Throat / Nose
_____ Skin Rashes / Hives
_____ Snoring
_____ Grief / Sadness
_____ Shortness of Breath
_____ Allergies / Asthma
_____ Low Resistance to Colds or Flu
_____ Sneezing
_____ Mild Fever Comes & Goes
_____ Smoke Cigarettes

***BODY TEMPERATURE***

*Please check all the apply:*

_____ Cold entire body
_____ Cold extremities
_____ Hot all day
_____ Hot only in afternoon
_____ Hot only at night
_____ Normal

***SPLEEN / STOMACH***

_____ Heaviness Anywhere in Body
_____ Fatigue / Worse After Eating
_____ Hard to Get Up in the Morning
_____ Edema (Swelling)
_____ Muscles Feel Tired Often
_____ Easily Bruising & Bleeding
_____ Bad Breath
_____ Decreased / Increased Appetite
_____ Crave Sweets
_____ Hypoglycemia
_____ Difficulty Digesting Oily Foods
_____ Nausea / Vomiting
_____ Gas / Belching
_____ Insulin Sensitivity
_____ Hemorrhoids
_____ Constipation
_____ Diarrhea
_____ Abdominal Pain
_____ Indigestion / Heartburn
_____ Over-Thinking
_____ Tendency to Gain Weight
_____ Brain Foggy

***ENERGY LEVEL*** – *Please circle:*
Low 1 2 3 4 5 6 7 8 9 10 High

## PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a "**C**" under the appropriate person's column. "**P**" should be used to indicate a past problem. Leave blank those that do not apply. If you require more space, use the reverse side of this form.

| | You | Father | Mother | Spouse | Brother(s) | | Sister(s) | | Children | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ***Age*** | | | | | | | | | | | |
| AIDS / HIV | | | | | | | | | | | |
| Alcohol | | | | | | | | | | | |
| Anxiety | | | | | | | | | | | |
| Arthritis | | | | | | | | | | | |
| Asthma / Hay Fever / Allergy | | | | | | | | | | | |
| Back Trouble | | | | | | | | | | | |
| Bursitis | | | | | | | | | | | |
| Cancer | | | | | | | | | | | |
| Constipation | | | | | | | | | | | |
| Depression | | | | | | | | | | | |
| Diabetes | | | | | | | | | | | |
| Digestive Trouble | | | | | | | | | | | |
| Headaches | | | | | | | | | | | |
| Heart Trouble | | | | | | | | | | | |
| Hepatitis | | | | | | | | | | | |
| High Blood Pressure | | | | | | | | | | | |
| Immune Disorder | | | | | | | | | | | |
| Insomnia | | | | | | | | | | | |
| Kidney Trouble | | | | | | | | | | | |
| Liver Trouble | | | | | | | | | | | |
| Migraine | | | | | | | | | | | |
| Neck Pain | | | | | | | | | | | |
| Thyroid Disorder | | | | | | | | | | | |
| Tobacco | | | | | | | | | | | |
| Weight Problem | | | | | | | | | | | |
| Other Emotional Problems:_____ | | | | | | | | | | | |
| Other:_____ | | | | | | | | | | | |

If any of the above family members are deceased, please list their age at death and cause.

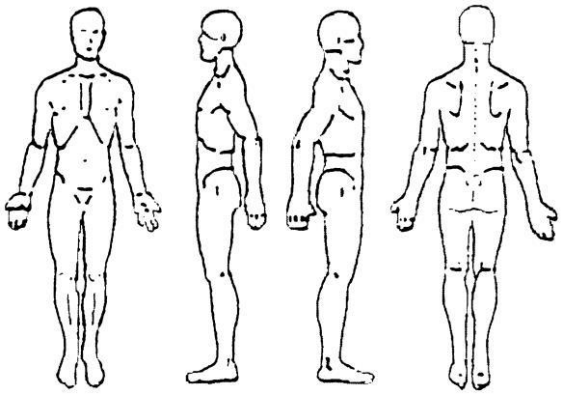
_____

**MUSCULOSKELETAL**

☐ Muscle Cramps – Where? ☐ Muscle Pain / Rheumatism – Where? ☐ Arthritis – Where?

☐ Joint Swelling – Where? ☐ Tendonitis – Where? ☐ Bursitis – Where?

**Please mark problem areas on diagram:**



***Describe Pain and Location***

☐ Sharp ☐ Burning ☐ Aching
☐ Fixed ☐ Other:_____

☐ Sharp ☐ Burning ☐ Aching
☐ Fixed ☐ Other:_____

☐ Sharp ☐ Burning ☐ Aching
☐ Fixed ☐ Other:_____

## Women Only

Hysterectomy – Ovaries Removed? ☐ Yes ☐ No

Could You be Pregnant Now? ☐ Yes ☐ No

Number Of: ___ Pregnancies ___ Miscarriages
___ Births ___ Abortions

Post-menopausal Bleeding ☐ Yes ☐ No

When did your last period end? _____

Number of days for monthly cycle? _____

Number of days bleeding lasts? _____

Describe Menstrual Flow:

☐ Heavy ☐ Moderate ☐ Light ☐ None

Color of Menstrual Flow:

☐ Dark ☐ Bright Red ☐ Slightly Reddish

Birth Control:

☐ None ☐ IUD ☐ Birth Control Pills
☐ Spermicides ☐ Barriers

***Do You Suffer From:***

☐ Cramping *(Mark as appropriate)*
- ☐ Severe ☐ Moderate
- ☐ Mild ☐ Before Period
- ☐ During Period ☐ After Period

☐ Clotting *(Mark as appropriate)*
- ☐ Bright in Color ☐ Dark in Color

☐ Bleeding Between Periods ☐ Infertility
☐ Pelvic Inflam. Disease ☐ Ovarian Cysts
☐ Endometriosis ☐ Hot Flashes
☐ Mstitis ☐ Breast Cysts
☐ Yeast Infection / Vaginitis / Other Discharge

☐ Premenstrual Syndrome *(Mark as appropriate)*
- ☐ Fluid Retention ☐ Cravings
- ☐ Fluctuating Emotions ☐ Irritability
- ☐ Tenderness in Breasts ☐ Depression
- ☐ Fatigue

## Men Only

☐ Impotence ☐ Weak Erection
☐ Discharge from Penis ☐ Prostate Problems
☐ Testicular Pain or Lump ☐ Infertility
☐ Premature Ejaculation ☐ Low Sex Drive

# Men and Women

## Supplements

| Name | Purpose | How Long |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Diet & Lifestyle

| What kinds (circle) | How much per day/week |
|---|---|
| Sugar: Candy | |
| Cookies / Baked goods | |
| Regular Soda / Diet Soda | |
| Chocolate | |
| Diary: Milk | |
| Cheese | |
| Yogurt | |
| Ice-cream | |
| White Flour: Bread | |
| Pasta | |
| Coffee | |
| Alcohol | |
| Protein 50g per day? | |
| Eggs | |
| Dark green/vegetables | |
| Fruits | |
| Eat Breakfast? | |
| Eat fast food / on the run? | |

## Additional Notes

Please tell us about your exercise (regular, minimal, etc.):

_____

Please list what you ate yesterday:

Breakfast_____

Lunch_____

Dinner_____

Snacks _____

# Acupuncture Informed Consent

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body (small amounts of electrical current may be applied to the needles). The purpose of acupuncture has been explained as the alleviation or cure of symptoms or disorders.

Acupuncture, acupressure, Moxa, cupping therapy, allergy elimination technique, nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis of treatment of any disease or injury. We recommend that you CONSULT YOUR PHYSICIAN for any serious conditions and receive at least two medical opinions. It is your right and responsibility for your own body.

I understand that complications may result from acupuncture treatment. Among these possible complications are: areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms. Being hungry, tired, or stressed can infrequently make the body more sensitive to the acupuncture treatment. Please tell your provider if you have any conditions that may inhibit blood clotting, such as hemophilia or coumadin use. Please use caution when walking with bare feet in the treatment room.

I further understand and agree to hold harmless, to indemnify and to protect against court action the individual therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises.

## Payment Practices

Wei's Chinese Medical Center gladly accepts health insurance, automobile insurance, and worker's compensation as payment. Insurance coverage depends upon your individual plan. Please call your insurance company to verify your acupuncture benefits. In the event your insurance does not cover acupuncture, discounted charges will be collected at the time of service.

## Payment Agreement

I authorize Wei's Chinese Medical Center to release any information required to process this claim to any insurance company or attorney in this case. I also authorize my insurance company or medical provider to release my medical records to Wei's Chinese Medical Center . This information is to be used for the purpose of processing my claims for benefits due. I hereby agree that a photocopy of the document is as valid and effective as the original.

I hereby authorize my insurance benefits to be paid directly to Wei's Chinese Medical Center. I assume full responsibility for and agree to pay all costs, charges, and expenses of every kind and description for services furnished by Wei's Chinese Medical Center . I agree to pay charges and services not covered by any insurance or other third-party payer and/or not paid to Wei's Chinese Medical Center for any reason within a reasonable time (as determined by Wei's Chinese Medical Center). The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator, or third party responsible for payment of the charges.

## Cancellation Notice

Please be considerate of your appointment time. We make every effort to respect your time and see you promptly when you are scheduled. Please call if you cannot make your appointment or you are running late. Patients who consistently miss their appointments or fail to cancel 24 hours in advance may be charged for their missed appointments.

I have read and understand the above Informed Consent statement. I agree to the conditions set forth in this statement.

**Patient's Name (Please print): _____**

**Signature of patient or legal guardian_____ Date_____**

# Acupuncture Privacy Practices

As your health care provider, we use your health information for evaluation and treatment; as well as to obtain payment for treatment. If you are referred to another health care provider, or at your request, your medical records may be shared with those providers. We may use your health care information without your authorization for the following reasons:

1. Public health safety
2. Auditing purposes
3. Emergencies
4. At the request of your insurance carrier
5. When required by law

In all other circumstances, we will ask your written permission to release your medical information in the form of a "Release of Medical Records" form. If you choose to sign such a form, you have the right to revoke that authorization at any time. If you would like to review our "Notice of Privacy Practices," please request a copy at the front desk. If, at any time, we change our policies regarding your medical information, you will be informed with a new "Privacy Practices" form to sign, as well as a new copy of "Notice of Privacy Practices."

You have the right to view and obtain a copy of your medical record. You also have the right to know to whom we have disclosed your medical records. If you believe the information in your medical record is not correct or missing information, you have the right to request that such information is corrected or added to your medical record.

If you have any questions or concerns about your medical records, please contact Wei's Chinese Medical Center, or you can file a written complaint with the U.S. Department of Health and Human Services. Wei's Chinese Medical Center is required by law to protect your medical information and provide this notice to you, along with your signature acknowledging your receipt of this information.

Wei's Chinese Medical Center reserves the right to change the privacy practices that are described in the "Notice of Privacy Practices." You may obtain a revised "Notice of Privacy Practices" by notifying the office of Wei's Chinese Medical Center and requesting a revised copy. Our office sends thank you cards for referrals, periodic newsletters, and participates in other non-private contact. This may be via email or postal service. Reminders of your appointments may be via email or telephone.

## Consent

I understand that I have a right to read the "Notice of Privacy Practices" prior to signing this form. The "Notice of Privacy Practices" describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations at Wei's Chinese Medical Center. This "Notice of Privacy Practices" also describes my rights, as well as the duties of the practitioner with respect to my protected health information.

I consent to the use or disclosure of my protected health information by Wei's Chinese Medical Center for the purpose of analyzing, diagnosing, or providing treatment; as well as obtaining payment for my health care bills or to conduct health care operations. I understand that analysis and treatment by Wei's Chinese Medical Center may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. is not required to agree to the restrictions that I may request. However, if Wei's Chinese Medical Center agrees to a restriction that I request, the restriction is binding on Wei's Chinese Medical Center. I have the right to revoke this Consent, in writing, at any time, except to the extent that Wei's Chinese Medical Center has taken action in reliance on this Consent.

My "protected health information" means health information, including any demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition that identifies me, or there is a reasonable basis to believe the information may identify me.

**Patient's Name (Please print):** _____

_____ _____

**Signature of patient or legal guardian** **Date**

# Financial Policy for Patient Care Services

Wei's Chinese Medical Center wants to provide the most efficient and affordable health care services, so it is necessary for us to have a financial policy stating our requirements for timely payment of services and products provided by our office. We welcome the opportunity to discuss any aspect of our financial policy.

To help us help you, please:

1) Provide us with accurate and updated information on yourself and your insurance company.
2) Pay at the time of service for your entire balance.
3) Discuss your account balance only with the front office staff. It is important for practitioners to be allowed to provide patient care. If the front office staff cannot help you, do not hesitate to contact the office manager.

**Insurance Patients:**
We are happy to file insurance claims as a courtesy to you. It is your responsibility to see that the claims are paid. As stated by your insurance company: **"Verification of benefits is no guarantee of payment."** If you have insurance and we file with your carrier for you, you will be responsible for all charges not paid by the insurance company. The balance due is your responsibility if we have not received payment from your insurance company within 60 days.

Wei's Chinese Medical Center sends claims with procedure codes to the insurance companies. Your insurance company then chooses the "reasonable and customary" amount to apply to your visit. Your insurance plan is a contract between you and your insurance company, therefore any amount applied toward your deductible must be paid in full.

By signing this financial policy:

1) You are authorizing Wei's Chinese Medical Center, their providers, and employees to release any necessary information related to this visit and all future visits to your insurance company for the purpose of claim(s) payment. You are giving authorization to submit your claims without obtaining your signature on each and every claim submitted.
2) You are authorizing your insurance company and your medical provider to release your medical records to Wei's Chinese Medical Center for the purpose of claim(s) payment.
3) You are authorizing your insurance company to pay any medical benefits and all future claims for services provided by our office directly to Wei's Chinese Medical Center.
4) You are giving Wei's Chinese Medical Center the right to speak with your insurance company, any third party insurance company, and your attorney regarding your claims and bills.
5) You agree that a photocopy of any document is as valid and effective as the original.

## Healthy People are Happy People

_____
Patient's Name (please print)

_____ _____
Responsible Party or Authorized Person Signature Date

_____ _____
Wei's Chinese Medical Center Signature Date