ACUPUNCTURE INFORMATION AND INFORMED CONSENT

Acupuncture is performed by the insertion of PRE-STERILIZED, DISPOSABLE acupuncture needles through the skin, and / or the application of heat stimulation to skin, or both, at certain points on the body. The benefits and risks of receiving acupuncture procedure and Chinese herbal consultation have been explained to me. Although rare, certain side effects may result from Acupuncture, I understand that each procedure or treatment has specific risks and benefits.

I have been informed of the risk and benefits of the procedure and products below that apply to my case: Acupuncture needles to stimulate points and meridians, including the specific risks of needling certain points and the use of mechanical stimulation of acupuncture points or acupressure.

I have been informed and understand the risks and side effects listed below:
1) Minor burning, 2) Needle sickness, 3) Broken needles, 4) Some pain at the site of needle insertion, 5) Infection, 6) The risks from needling in the vicinity of an infection, and 7) Potential side effects of Chinese herbs.

I understand that Dr. Xie's Acupuncture Clinic may record information concerning my treatment in electronic and in other physical form. Such information may be released by Dr. Xie's Acupuncture Clinic for the purposes authorized on this form. I understand that portions of my records may be disclosed to other personnel for the purpose of management, financial audits, and licensure and program evaluation without my express consent. I understand that the practice of Acupuncture and Herbal Consultation is not an exact science and I acknowledge that no guarantees have been made to me. I understand that licensed Acupuncturists perform these procedures.

RECORDS RELEASE AUTHORIZATION
I understand that I am responsible for my bill.
I authorize payment directly to Dr. Xie's Acupuncture Clinic.
I authorize the use of this information to my insurance submissions.
I authorize release of information to all my insurance companies.
I authorize my clinician to act as my agent to obtain payment from my insurance companies.
I permit a copy of this authorization to be used in place of the original.
I authorize Dr. Xie's Acupuncture Clinic to make copy of my previous medical information which I have provided.
I authorize the use of my previous medial information to be the basis of acupuncture procedure and herbal consultation.
This authorization is not intended to allow the release of records regarding my treatment for services requiring a restricted release under State or Federal Law.

Patient's Name (Print) _____

Patient's Signature _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES
I have received a copy of Dr. Xie's Acupuncture Clinic Notice of Privacy Practices. I understand this information defines my rights under 45 CFR 164.528 of the federal regulations and is intended to comply with federal patient privacy rights. I have been notified that an electronic copy of this Notice of Privacy Practices can be downloaded from https://www.acupunctureforhealthcare.com/notice-of-privacy-practices/ if I prefer.

Patient's Signature _____ **Date:** _____

CONSENT FOR A MINOR PATIENT
I authorize Dr. Xie's Acupuncture Clinic and whomever it designates as assistants to administer Acupuncture procedure and Chinese herbal consultation as deemed necessary to my _____ (relationship).

Minor Patient's Name _____

Parent / Custodian's Name and Signature_____ **Date** _____

PATIENT INFORMATION (Please Print)

Patient's Name: _____ Sex: M _____ F _____

Date of Birth _____/_____/_____(mm/dd/yy) **Marital Status**: Single _____Married ____Divorced _____Others _____

Address _____ City_____ State_____ Zip _____

Occupation _____E-mail _____@_____

Phone Number: Home _____Work _____ Cell _____

Referred by _____

Employer Information _____

Address _____ City _____ State_____ Zip _____

Emergency Contact
Name _____ Relationship _____

Address _____ City_____ State_____ Zip _____

Phone Number: Primary Number _____ Secondary Number_____

Insurance Information (Please Print):

Insurance Company: _____ **I.D. NUMBER**: _____ **POLICY GROUP #**: _____

Subscriber's Name: _____ **Sex**: M _ F _ **Date of Birth** _____/____ /___ (mm/dd/yy) **Phone #**_____

Relationship to Patient: Self __ Spouse _ Child __ Other (specify) _____ **Subscriber's Signature**: _____

Subscriber's Address _____ City _____State_____ Zip _____

Can we send you the following information electronically via email and cell phone text message?

Email address: _____@_____ **Cell Phone Number:** _____

- **Appointment reminders?** Yes _____ No_____
- **Information about your herbs and supplements?** Yes _____ No_____
- **Invoice and billing statements?** Yes _____ No_____

Family History: Does your mother, father, grandparents, brothers, sisters, aunts, uncles, or children have any of the following? If yes, who? If family history is unknown, please check unknown. ☐ **Unknown/Adopted**

- **Allergy** Yes___ No___; If yes, who? _____
- **Bleeding Disorder** Yes___ No___; If yes, who? _____
- **Cancer** Yes___ No___; If yes, who? _____
- **Depression** Yes___ No___; If yes, who? _____
- **Diabetes/Prediabetes** Yes___ No___; If yes, who? _____
- **Heart Problems** Yes___ No___; If yes, who? _____
- **High Blood Pressure** Yes___ No___; If yes, who?_____
- **Lung Problems** (asthma)Yes___ No__ ; If yes, who? _____

Social History:

- **Cigarette Smoking?** Yes___ No___; Packs Per day: _____How long? _____
- **Past smoking?** Yes__ No___; When did you quit? _____ **Smoke Exposure?** Yes_____ No_____;
- **Do you drink alcohol?** Yes____No_____; How many alcoholic drinks per week? _____
- **Substance Abuse of drug use?** Yes___ No___; If yes, then what type of substance or drug? _____

Living Situation:

- Are there pets in the home? Yes___ No___; If yes, what type of pet: _____

Exercise: Yes___ No ___; If yes:_____times/week; Type of exercise: _____

Diet: ☐ Regular ☐ Diabetic ☐ Low Fat ☐ Low Salt ☐ Other: _____ **Hobbies** _____ _

Patient's Name _____

Review of Systems: Please check the "Yes" or "No" box to indicate if you have any of the following symptoms. For any "Yes" response, please check the "current" box if this symptom relates to the reason for your visit today.

Note: This page is not PDF fillable. You may complete this page when you are interviewed by your acupuncturist in the clinic.

	Yes	No	Current
General			
Chills	□	□	□
Fever	□	□	□
Fatigue	□	□	□
Night sweating	□	□	□
Weight gain/ loss	□	□	□
Daytime sleepiness	□	□	□
Sleeping difficulties	□	□	□
Allergy			
Environmental allergy	□	□	□
Sneezing	□	□	□
Dermatology (Skin)	□	□	□
Rash	□	□	□
Itching	□	□	□
Hives	□	□	□
Changes in Moles	□	□	□
Scalp problems	□	□	□
Hair changes	□	□	□
Bruising	□	□	□
Yellowing of skin	□	□	□
New lesions	□	□	□
EYES			
Eye pain/pressure	□	□	□
Visual disturbances	□	□	□
ENT			
Ear ache	□	□	□
Ring in ears	□	□	□
Dizziness	□	□	□
Decreased hearing	□	□	□
Nasal congestion	□	□	□
Nose bleeding	□	□	□
Snoring	□	□	□
Throat clearing	□	□	□
Sore throat	□	□	□
Throat hoarseness	□	□	□
Respiratory			
Cough	□	□	□
Wheezing	□	□	□
Shortness of breath	□	□	□
Coughing up blood	□	□	□
Sputum production	□	□	□
Breast			
Breast Lump	□	□	□
Breast pain	□	□	□
Nipple discharge	□	□	□

	Yes	No	Current
Gastrointestinal			
Difficulty in swallowing	□	□	□
Heartburn	□	□	□
Nausea	□	□	□
Abdominal pain	□	□	□
Stomach pain	□	□	□
Constipation	□	□	□
Diarrhea	□	□	□
Black, tarry stool	□	□	□
Female Genitourinary			
Vaginal bleeding problem	□	□	□
Pelvic pain	□	□	□
Urinary complaints	□	□	□
Vaginal discharges	□	□	□
Male Genitourinary			
Blood in urine	□	□	□
Urination difficulty	□	□	□
Neurological			
Dizziness	□	□	□
Faintness	□	□	□
Headache	□	□	□
Memory problems	□	□	□
Seizures	□	□	□
Tremors	□	□	□
Weakness of limbs	□	□	□
Psychiatric:			
Anxiety	□	□	□
Mood swing	□	□	□
Depression	□	□	□
Change in sleep pattern	□	□	□
Endocrine:			
Appetite change	□	□	□
Excessive thirsty	□	□	□
Hot flashes	□	□	□
Hematology			
Anemia	□	□	□
Blood clots in legs / lungs	□	□	□
Easy bruising	□	□	□
Bleeding problem	□	□	□

Patient's Name _____

Use of Medications, Herbal and Other Supplements

You may provide a list of medications you currently use.

Medications	No	Yes	Dosage and Frequency
Analgesics (Aspirin, Ibuprofen, Naproxen, Sodium, etc.)			
Cardiovascular Agents (Digoxin, Lanoxin, Captopril, etc.)			
Laxatives			
Antacids (Bicarbonate of Soda, Calcium Carbonate, etc.)			
Sedative, Antianxiety, Antipsychotic drugs (Lithium, Thioridazine, Chlorpromazine, Prozac, etc.)			
Anti-Inflammatories (Predinisone, other corticosteroids, NSAIDs, etc.)			
Respiratory Agents (Theophylline, etc.)			
Diuretics (Lasix)			
Antibiotics			
Elixirs containing sorbitol (Theophylline, Acetaminophen, etc.)			
Insulin or Diabetic Pills			
Sleeping Pills			
Thyroid Medication			
Blood-thinning Pills			
Seizure Medication			
Weight Reducing Pills			
Birth Control Pills			
Hormones			
Blood Pressure Pills			

List other (including over-the-counter medications) you currently use:

List herbal, or other natural supplements, vitamins and minerals you currently use:

Allergies: (List allergen name and the type of reaction, write n/a if none)

Medication (s): _____ Reaction: _____

Food/Insects/Other: _____ Reaction: _____

Chinese Medicine Consultation Review

Current Complaints:

#1_____For How long?_____

#2_____For How long?_____

#3_____For How long?_____

Please check the appropriate descriptions and fill in the necessary information:

Emotions: Depress ____ Sad ____ Panic attack ____ Anger ____ Anxiety ____

Energy: Low ____ Exhausted ____ Hyperactive ____

Sleep Pattern: Have difficulty falling asleep _____; Wake up _____ (times per night); Wake up too early ____;

Not able to go back to sleep after waking up _____

Temperature: Fever ____ Cold hands ____ Cold feet ____ Hot flash ____

Sweating: Too little ____ Too much ____ Night sweats ____

Sensitive or Allergic to: Cold ____ Hot ____ Dampness ____ Dust ____ Hay ____ Pollen ____

Food _____Others _____

Appetite & Digestion: Poor appetite ____ Rapid hungering ____ Craving _____Nausea ____ Bloating ____ Gas ____

Bowel Movement: Constipation ____Diarrhea ____ Loose ____ Watery ____ Incomplete defecation ____

Hard and dry ___ Strong smell ____ with mucous ___ with blood ____, Time of day when BM occurs: ____

Body Weight: Overweight __ Underweight ___ How many pounds would you like to gain or lose? _____

Liquid Intake: Dry mouth ____Thirsty ___Drink a lot of water___ Not thirsty, but drink a lot of water anyway ____

Urination: Frequent ____ Urgent ____ Burning ____ Painful ____ Cloudy ____ Dark color ____ Foul smell ____

Retention ____ Bloody ____ Number of times per day: _____ Number of times per night: _____

Menstrual Cycle and Pregnancy (Female patient only):

Pregnant: Yes _____ No _____

Last Menstrual Period: From _____ to _____

Menstrual Cycle: Average days of the cycle _____, days of period _____ clots _____ menstrual pain _____,

Menstrual Color: pale red _____ bright red _____ or dark red _____

Emotion around the period: depression ____ irritability ____ anger ____ crying ____ anxiety ____ others: _____

Emotions occur: before the period ____ during the period ____ after the period ____

Is there any additional information related to your health conditions you would like your acupuncturist to know?

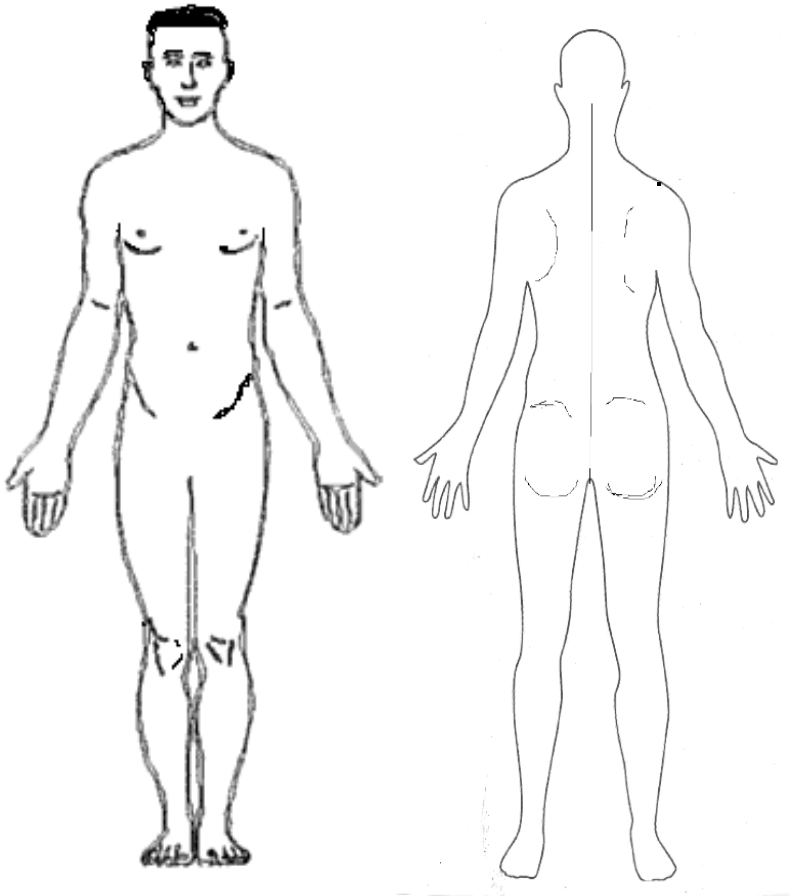
Patient's Name _____

For patient with any pain and related condition(s), please check the appropriate boxes below and mark on the figures.

Location of Pain	Scores (1-10)	Duration	Constant /intermittent	Stabbing	Heavy	Sore	Dull	Burning	Numb/ Tingling
Headache									
Jaw									
Upper back									
Middle back									
Lower back									
Chest									
Neck									
Shoulders									
Upper Arm									
Elbows									
Forearm									
Wrists									
Hands									
Buttocks									
Thighs									
Knees									
Legs									
Ankles									
Foot									

Please also mark your conditions on the figure below for location of pain and sensation.

Pain: *X*, Spasm: S, Numbness: N, Weakness: W, Cold Sensation: C, Burning Sensation: B, Heavy Sensation: H



Used by the acupuncturist Only:

Tongue

Pulse:

TCM Assessment:

Acupuncture Session 1:
Face to Face time:
Points:

Acupuncture Session 2:
Face to Face time:
Points:

Additional Treatments

Infra-red heat:
Cupping:
TuiNa/Stretching:
Exercise:
Guasha:

Signature:

Date:

Patient's Name _____