ABOUT YOU

Date:

Mr. Mrs. Ms. Dr. Pastor Name _____ I go by _____

Mailing Address _____ City _____ St ____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ (for contact purposes only, will not be sold)

Occupation _____ SSN _____ Birth Date _____

Employer _____ Address _____

Spouse's Name _____ Spouse SSN _____ Spouse Employer _____

Spouse Phone _____ Spouse Occupation _____ Spouse Birth Date _____

Emergency Contact Name _____ Phone _____

How, or from whom, did you hear about our office? _____

REASON FOR THIS VISIT

IF THIS IS AN ACCIDENT RELATED INJURY, please see the receptionist for an Accident Form. Thank you!

Describe the purpose of your visit _____

When did this episode begin? _____ Has it occurred before? When? _____

Is the condition: (circle one) Constant – 100% of the time Frequent – 75% Intermittent – 50% Occasional – 25%

How severe is it (on a scale of 1- 10) _____ Does it radiate to other parts of your body? _____

What makes it better? _____ What makes it worse? _____

Other Doctors seen for this condition: No Yes Who? _____

Type of treatment _____ Results _____

What do you believe is wrong with you? _____

Does this condition interfere with: (circle all that apply) Work Family Sleep Daily routine Recreation Other activities

HEALTH HISTORY

What accidents, falls, injuries have you had? NOTE: This includes childhood traumas. Please include approximate dates:

_____

_____

Have you broken any bones? Which ones? How? When? _____

List all surgeries that you have had and approximate date _____

Drugs currently taken and reason for use _____

Previous Doctor's and date of last visit _____

Were there any complications during your birth? _____

Type of birth (circle all that apply) Natural Drug induced Cesarean Forceps Suction

Height _____ Weight _____

DAILY LIFE

Do you smoke? No Yes _____ packs/day Do you drink alcohol? No Yes Frequency? _____

Do you eat nutritional supplements? No Yes Which ones? _____

How much water do you drink? _____ Oz./day

Do you drink soda? No Yes Frequency? _____ Do you drink coffee? No Yes _____ Cups per day

Have you ever been on a restricted diet? No Yes If yes, explain _____

Do you have pets? No Yes If yes, what kind? _____

How often do you exercise? _____ Days/week What types of exercise? _____

How long do you do each of these during the day?

Standing _____ hrs/day Sitting _____ hrs/day Computer _____ hrs/day Driving _____ hrs/day

What activities have you had to restrict due to health problems? _____

_____

HEALTH CONDITIONS

Please check each of the diseases or conditions that you now have or have had in the past.

- ☐ Current Infection
- ☐ Sinus problems
- ☐ Dizziness
- ☐ Loss of sleep
- ☐ Frequent neck pain
- ☐ Pain between the shoulders
- ☐ Numbness or pain in arms / hands / legs
- ☐ Lower back pain
- ☐ Foot problems
- ☐ Digestive problems
- ☐ Heart attack / stroke
- ☐ Skin Conditions / Rashes
- ☐ Hepatitis
- ☐ Heart surgery / pacemaker
- ☐ Cancer
- ☐ Anemia
- ☐ Arthritis
- ☐ Diabetes
- ☐ Shingles
- ☐ Kidney problems
- ☐ Liver problems
- ☐ High / low blood pressure
- ☐ Breathing difficulty
- ☐ Asthma
- ☐ Thyroid problems
- ☐ Osteoporosis / Osteopenia
- ☐ Blood clots / Varicose veins
- ☐ Food Allergies
- ☐ Others not listed _____

_____

_____

For Women:

Are you pregnant? No Yes

Are you nursing? No Yes

- ☐ Painful periods
- ☐ Irregular cycle

UNDERSTANDING INSURANCE

I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. Although the doctors office will attempt to determine my health insurance benefits, it is ultimately my responsibility to understand these benefits. Furthermore, I understand that the doctors office will prepare any necessary forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctors office will be credited to my account upon receipt. However, I clearly understand that all service rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care, any fees for professional services rendered me will be immediately due and payable. I authorize assignment of my insurance benefits (if applicable) directly to the provider for services rendered.

Signature: _____ Date: _____

Patient's relation to insured: ☐ Self ☐ Spouse ☐ Child

Name of Primary Insured: _____ Insured's Date of Birth: _____

SHENDAO ACUPUNCTURE

Name:_____ Date:_____

Family Medical History: Please check all applicable

- ☐ Cancer
- ☐ High blood pressure
- ☐ Allergies
- ☐ Diabetes
- ☐ Stroke
- ☐ Seizures
- ☐ Asthma
- ☐ Heart disease

Please check any symptoms you have had in the last three months:

GENERAL

- ☐ Chills
- ☐ Fevers
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (cold or hot)
- ☐ Thirst, no desire to drink
- ☐ Fatigue
- ☐ Sudden energy drop
  Time of day?
- ☐ Edema
  Where?
- ☐ Poor balance
- ☐ Cravings
- ☐ Change in appetite
- ☐ Poor appetite
- ☐ Weight gain
- ☐ Weight Loss

HEAD, EYES, EARS, NOSE AND THROAT

- ☐ Migraines
- ☐ Headaches
  *When?*_____
  *Where?*_____
- ☐ Spots in front of eyes
- ☐ Eye dryness
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Itching in ear
- ☐ Nose bleeds
- ☐ Sinus congestion
- ☐ Nasal drainage
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Recurrent sore throats
- ☐ Hoarseness
- ☐ Sores on lips or tongue
- ☐ Other head or neck problems

_____

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest discomfort/pain
- ☐ Heart palpitations
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Fainting
- ☐ Difficulty breathing
- ☐ Other heart or blood vessel

_____

RESPIRATORY

- ☐ Cough
- ☐ Asthma/wheezing
- ☐ Pain with a deep breath
- ☐ Difficulty breathing when lying down
- ☐ Production of phlegm
  *What color?*_____
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Other lung problems

_____

GASTROINTESTINAL

- ☐ Bad breath
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Belching
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Chronic laxative use
- ☐ Blood in stools
- ☐ Abdominal pain or cramps
- ☐ Gas
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Other stomach/intestinal problems

_____

Please continue to the reverse side…

SHENDAO ACUPUNCTURE

GENITO-URINARY

- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Decrease in flow
- ☐ Unable to hold urine
- ☐ Dribbling
- ☐ Kidney stones
- ☐ Impotency
- ☐ Change of sexual drive
- ☐ Sores on genitals

Do you wake up to urinate?

☐ Yes ☐ No

If yes, how often?_____

Any particular color?

☐ Other genital or urinary system problems

_____

PREGNANCY AND GYNECOLOGY

Number of:

Pregnancies _____

Births _____

Premature Births_____

Miscarriages _____

Abortions _____

Age at first menses:_____

# of days between menses:____

Duration of menses (days):____

First date of last menses:

_____

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation
- ☐ Clots
- ☐ Menopause

*Age?*_____

*Year?*_____

- ☐ Vaginal discharge
- ☐ Postcoital bleeding
- ☐ Vaginal sores

Date of last Pap:_____

- ☐ Breast lumps
- ☐ Nipple discharge

Do you practice birth control?

☐ Yes ☐ No

If yes, what type and for how long?

_____

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Weakness
- ☐ Sleep disorder
- ☐ Concussion
- ☐ Bad temper
- ☐ Loss of control/violence potential
- ☐ Depression
- ☐ Lack of coordination
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Easily susceptible to stress
- ☐ Substance abuse
- ☐ Anxiety

Have you ever been treated for emotional problems?

☐ Yes ☐ No

Have you ever considered or attempted suicide?

☐ Yes ☐ No

Other neurological or psychological problems:_____

_____

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

Nature of Treatment: Your treatment may include acupuncture, cupping, electric or magnetic stimulation, Chinese herbs, dermal friction (Gua Sha), infra-red heat lamps, sound therapy, therapeutic exercises and dietary counseling based on the fundamentals of Chinese Medicine.

Risks of Treatment: Acupuncture has been shown to be relatively safe with little to no side effect. However, as with any therapy there are potential risks. These risks may include but are not limited to:

- Discomfort during and after needle insertion
- "Needle Sickness" (dizziness, fainting, nausea)
- Localized swelling and/or bruising
- Minor burns with the use of moxa
- Gastro-intestinal upset with the use of Chinese herbs
- Possible temporary aggravation of symptoms or new symptoms
- Broken needle (very rare with the use of disposable needles)
- Infection (also rare with the use of disposable needles)

Special Situations: Please notify your practitioner if you are currently pregnant or trying to become pregnant. Some herb and acupuncture points are contra-indicated during pregnancy. Additionally, you need to inform your practitioner if you have a bleeding disorder, wear a pacemaker or have other special medical devices.

I CHARGE A $35 CANCELLATION FEE FOR APPOINTMENTS CANCELLED LESS THAN 24 HOURS IN ADVANCE. THIS FEE IS NOT COEVERED BY ANY INSURER AND IS THE PATIENT'S RESPONSIBILITY.

I, _____, request and consent to the treatment of acupuncture and other Oriental Medicine procedures. I understand that my signature indicates that I have read and understand procedure and financial liability regarding my treatment. I understand that if I have any questions about this information, I should directly ask the practitioner to explain them. I hereby release Shendao Acupuncture from all liability that may occur in connection with the above mentioned procedures, except for failure to perform the procedure as defined under Washington state law.

NOTICE OF PRIVACY PRACTICES
Shendao Acupuncture
Denise Fiedler, L.Ac

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

We at Shendao Acupuncture with Denise understand that your trust in us is our most important asset. To preserve that trust, we want you to understand our commitment to protecting your privacy.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary to a home health agency that provides care to you. For example, your protected health information may be provided to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for acupuncture care may require that your relevant protected health information be disclosed to the health plan to obtain the necessary approval.

Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room hwen your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations with your authorization. These situations include: as required by Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration Requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ donation; Research: Criminal Activity, Military Activity and National Security; Workers' Compensation; Inmates. Required Uses and Disclosure: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures

These will be made only with your consent, authorization, or opportunity to object unless required by law. We do NOT sell your non-public information to anyone. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action on reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information:

You have the right to inspect and copy your protected health information.
Under federal law, however, you may not inspect or copy the following records: psychotherapy; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Your request for inspection must be in writing. Record copying will be at accepted legal copying fees.

You have the right to request a restriction of your protected health information.
This means that you may ask us no to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state that specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to the Secretary of Health and Human Services, or us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

Security Measures
We restrict access to non-public information about you to those individuals who need to know that information at levels necessary to conduct our business. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your non-public protected health information.

By law, we cannot share your information about care or condition to anyone including your spouse without written consent from you, the patient. However, we assume that we have your permission to leave messages on your telephone answering machine or voice mail, unless requested by you, the patient, not to do so. This denial of access needs to be made in writing.

This notice was published and becomes effective April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.
Signature below is only acknowledgement that you have received this Notice of Privacy Practices.

Print Name _____ Signature: _____ Date: _____