NC Acupuncture and Wellness Clinic

New Patient History Questionnaire

Full Legal Name: _____ Gender:____ Phone: _____
(姓名) （性别） （电话）

Address: _____
（家庭住址）

City: _____ State:_____ Zip:_____ Email:_____
（城市） （州） （邮编） （电邮）

Birth date:_____ Age:_____ Height:_____ Weight:_____
（出生日期） （年龄） （身高） （体重）

Employer:_____ Position: _____
（公司） （职业）

Emergency Contact(s): _____ Phone:_____
(紧急联络人) （联络电话）

Primary Health Complaint (List one) :_____
(主诉 – 只列出一个)

Please circle a number on the scale below about the complaint:
（从好到坏分10 级，请圈出你的痛苦指数）

Best 1 2 3 4 5 6 7 8 9 10 Worst
（一般） （糟糕）

How long it has been:_____
（持续多长时间）

Have you seen other health care providers for the primary health complaint? Yes / No
（你以前有去过别的医生那里治疗这个问题吗）

What type of practitioner(s) have you seen? _____
（如果是，是哪种医生）

Family history of the primary health complaint: _____
（有关主诉与家庭病史）

Other Health Complaint(s) : _____
(其他健康问题)

Allergies (drug, chemical, food):_____
（过敏，包括药物，食物和其他）

Current exercise program(s):_____
（现在的运动锻炼）

Do you smoke? _____ Do you rink coffee or caffeinated drinks?_____
（吸烟） (喝咖啡吗)

Do you drink alcohol?_____ How much per day?_____
（喝酒吗） （每天喝多少）

Have you ever been diagnosed with any of the following? (Please mark " X" the following conditions which you have) （请问你又被诊断为一下疾病吗?请在此种疾病后画叉）

Asthma_____ Anemia_____ Arthritis (osteo）_____ Rheumatoid _____ Anxiety_____
（哮喘） (贫血） (关节炎骨性） (风湿性） （紧张）

Congestive Heart Failure_____ Cancer/Tumor_____ Colitis_____ Depression_____
（心力衰竭） (癌症，肿瘤） (结肠炎） (抑郁症）

Diabetes_____ Epilepsy_____ Fibromyalgia_____ Gastritis_____
（糖尿病） (癫痫） (纤维肌痛) （胃炎）

High Blood Pressure_____ Heart Attack_____ HIV/AIDS_____
（高血压） （心梗） （艾滋病）

Hepatitis A, B, C, D(circle)_____ Irritable Bowel Syndrome_____
（肝炎A,B C D 型） （肠易激）

Multiple Sclerosis_____ Nephritis_____ Stroke_____ Systemic Lupus_____
（多发性硬化症） （肾炎） （中风） （红斑狼疮）

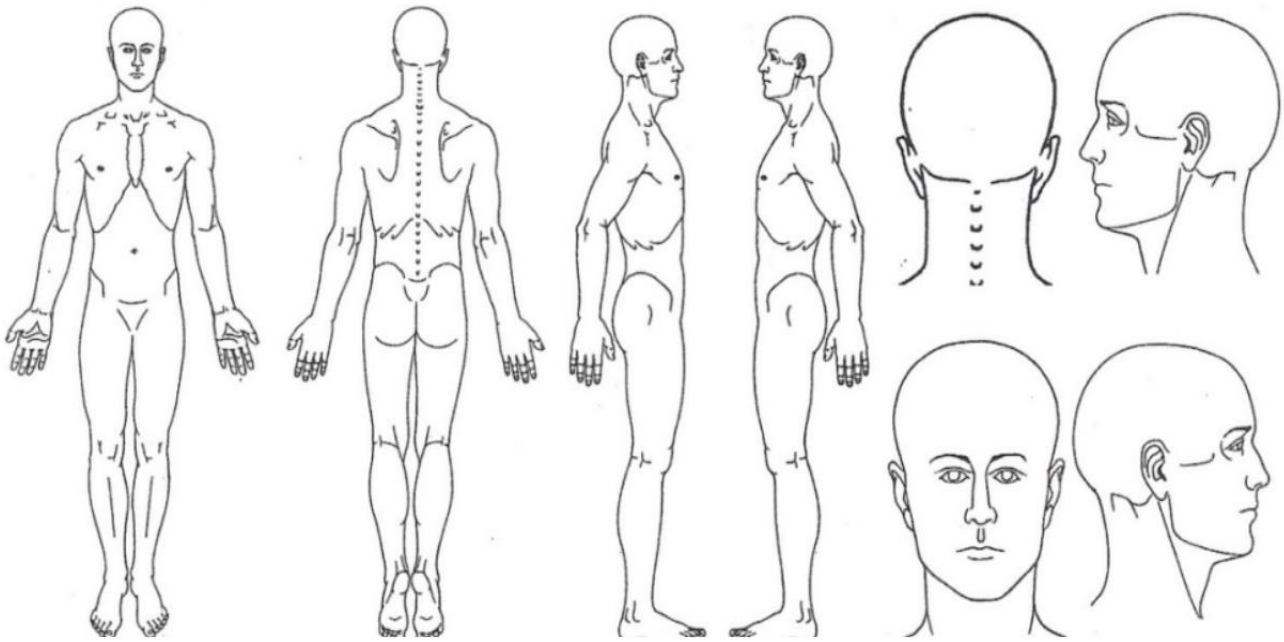
TMJ(jaw pain) _____ Thyroid Disease_____ Ulcers_____
（下颌关节痛） (甲状腺问题） （溃疡）

Surgery_____
（手术史）

Others _____
(其他）

Please indicate the location and sensation of your body pain using the following symbols:

^ ^ ^ ^ ^ ^ Numbness
0 0 0 0 0 0 0 Pins and Needles
x x x x x x Burning
* * * * * * Aching/Dull
////// Stabbing/Sharp
EEEEE Electrical



********** **OFFICE POLICIES** **********

Welcome to the NC Acupuncture & Wellness Clinic (The Clinic). We would like all clients feel comfortable and receive the best care possible. We are here to answer any questions regarding visit, billing, policies or etc.

The Notice of Privacy Practices: By signing this form, I acknowledge receipt of the Notice of Privacy Practices from The Clinic. This Notice of Privacy Practice information about how it may be used and disclosed protected health information.

Health Insurance, Work Compensation, any related claim or reimbursement: I consent to waive and decline using my health insurance, work compensation, or other types of coverage / reimbursement for The Clinic services. I have confirmed and fully understood that The Clinic has no obligation to provide further information or resources to support any of my related claim or reimbursement (HSA, FSA…).

Appointment Re-schedule, Cancellation, No-Call and No-Show Policy: In any circumstances, re-schedule or cancellation of appointment with less than 48 hours notice (no re-schedule or change for pre-paid*), client will be charged full session price. No-Call and No-Show client will be charged full session price, and may result in pre-paid visits or discharge from the practice. More than 10 minutes late arrival to the appointment, it will be canceled by default and the client will be charged full session price.

Re-Examination or Primary Health Issue Change:
Each fee will be applied:
1. On or over 30 calendar days from the last appointment date,
2. Change of Primary health issue. Example: If a client primary health issue is low back pain, and then change the primary issue to vertigo.

***Pre-Paid:** Pre-paid amount is non-refundable and non-transferable. Each pre-paid amount is only used for a scheduled appointment, it does not allow to reschedule or change in any circumstances.

Support Document: The Clinic has no obligation to support, complete or sign any documents from third party.

Products Return: No return and refund for all products and services.

The Clinic has reserved the right to change the policies and service fees without notice.

By signing below, I agree to comply with The Clinic Policies stated above which I have read and understood.

Signature:_____ Date:_____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. 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.

PATIENT NAME:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

Women Only:

Are you Pregnant?_____ Are you taking birth control pills?_____

Are you past menopause? Yes_____ no_____
If you are taking hormones, what kind?_____

Please describe your periods. If you are past menopause, please describe them as they generally used to be.

Cramping:	none____	a little____	a lot____
Clotting:	none____	a little____	a lot____
Bleeding:	light____	moderate____	heavy____
Depression:	none____	a little____	a lot____
Irritability:	none____	a little____	a lot____
Anxiety:	none____	a little____	a lot____
Breast tenderness:	none____	a little____	a lot____
Increased other pain:	none____	a little____	a lot____

Frequency: regular____ occurring every ____days
Irregular____ occurring between __and____days

How many childbirths?____
How many Caesarean sections?____