ACUPUNCTURE & HERB CLINIC, LLC. • 21351 GENTRY DRIVE #110 • STERLING, VA 20166 • (703) 430-7058

Patient Registration

Welcome to our office! We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Pleased assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below.

Last name: _____ First name: _____ Middle (initial):_____

Date of Birth: _____ Age: _____ Marital Status: _____ Sex: ___

Home Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if Different):_____

City: _____ State: _____ Zip: _____

Email address: _____

Phone: Home: _____ Cell: _____ Work: _____

Occupation: _____ Employer's Name: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Spouse Name: _____ Employer: _____

Your Physician's Name: _____

NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Address: _____ City: _____ State: ___ Zip: _____

Home Telephone: _____ Work Telephone: _____

Nearest Relative (not living with you): _____

Home Telephone: _____ Work Telephone: _____

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Health History Questionnaire for Patients

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. **All of your answers will be held absolutely confidential**. If you have questions, please ask us. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the **Comments** section. Thank you!

Date: _____

Last name:_____ First name: _____ M.I.:_____

Date of birth: _____ Age: _____ Sex: _____ Weight: _____ Lbs.

Occupation: _____ Marital Status: S M D OTHER: _____

Whom May We Thank for Referring You to Our Practice? _____

Have you tried Acupuncture or Chinese herbal medicine before? _____

MAIN PROBLEM(S) YOU WOULD LIKE TO ADDRESS: _____

_____

To what extent does this problem affect you daily activities (work, sleep, eating, etc…)?

_____

How long has it been since you first noticed any symptoms? _____

Have you been given a diagnosis for the problem by your family physician? ____yes _____no

If so, what is it? _____

What kinds of treatment have you tried? _____

Comments: _____

_____

_____

_____

_____

_____

_____

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PAST MEDICAL HISTORY (If yes, please include dates)

___ Allergies _____ ___ Rheumatic Fever_____

___ Cancer _____ ___ Surgeries_____

___ Diabetes_____ ___ Venereal Disease_____

___ Hepatitis_____ ___ Thyroid Disease_____

___ High Blood Pressure_____ ___ Seizures_____

___ Birth Trauma (prolonged Labor, forceps delivery, etc…) _____

___ Other significant illness (describe) _____

___ Accidents or Significant Trauma (describe) _____

OTHER RELEVANT MEDICAL HISTORY _____

_____

FAMILY MEDICAL HISTORY

___ Allergies _____ ___ Cancer _____ ___ Seizures _____

___ Diabetes _____ ___ Heart disease _____ ___ Stroke _____

___ Asthma _____ ___ High Blood Pressure _____ ___ Other _____

OCCUPATION

Occupational stress factors (physical, psychological, chemical): _____

_____

LIFESTYLE

Do you follow a regular exercise program? _____ If so, please describe:_____

Please describe your average daily diet: _____

Please check any of the following habits that apply. How much and how often do you use them?

___ Cigarette Smoking _____ ___ Coffee, tea, or cola _____

___ Alcoholic beverages _____ ___Other: _____

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List any medications taken within the last two months (vitamins, drugs, herbs, etc…): _____

_____

Please describe any use of drugs for non – medical purposes: _____

_____

PLEASE CHECK ANY CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST SIX MONTHS.

INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION.

Example: __ Insomnia 3 months

GENERAL

☐ Poor appetite _____ ☐ Weight Gain _____ ☐ Weight loss _____

☐ Insomnia _____ ☐ Disturbed sleep _____ ☐ Night sweat _____

☐ Fever _____ ☐ Chills_____ ☐ Sweat easily _____

☐ Changes in appetite ____ ☐ Cravings _____ ☐ Strong thirst_____

☐ Tremors _____ ☐Poor balance _____ ☐ Localized sleep _____

☐ Sudden energy drop (time of day?) _____ ☐Bleeding or bruising easily _____

Other unusual or abnormal conditions you have noticed in your general sense of health: _____

_____

_____

SKIN AND HAIR

☐ Rashes _____ ☐ Eczema _____ ☐ Recent moles _____

☐ Ulcerations _____ ☐ Pimples _____ ☐ Hives _____

☐ Dandruff _____ ☐ Itching _____ ☐ Hair loss _____

☐ Changes in texture of hair or skin _____

Other problem: _____

_____

_____

HEAD, EYES, EARS, NOSE, THROAT

☐ Headaches (where?, when?) _____

_____

☐ Migraines _____ ☐ Concussions _____ ☐ Dizziness _____

☐ Color blindness _____ ☐ Blurry vision_____ ☐ Cataracts _____

☐ Glasses _____ ☐ Spots in front of eyes _____ ☐ Eye pain_____

☐ Poor vision _____ ☐ Eye strain _____ ☐ Night blindness _____

☐ Nose bleeds _____ ☐ Sinus problems _____ ☐ Facial pain _____

☐ Grinding teeth _____ ☐ Teeth problems _____ ☐ Sores on lips or tongue _____

☐ Earaches _____ ☐ Ringing in ears _____ ☐ Poor hearing_____

☐ Recurrent sore throat _____ ☐ Jaw clicks _____

Any other head or neck problems: _____

_____

CARDIOVASCULAR

☐ Dizziness _____ ☐ High blood pressure _____ ☐ Low blood pressure _____

☐ Swelling of feet ____ ☐ Cold hands or feet _____ ☐ Swelling of hands _____

☐ Fainting _____ ☐ Blood clots _____ ☐ Phlebitis _____

☐ Chest pain _____ ☐ Difficulty in breathing ____ ☐ Irregular heart beat _____

Any other heart or blood vessel problems? _____

_____

RESPIRATORY

☐ Cough _____ ☐ Bronchitis _____ ☐ Coughing up blood _____

☐ Asthma _____ ☐ Pneumonia _____ ☐ Excessive phlegm (color?)_____

☐ Difficulty breathing when lying down_____ ☐ Pain with deep inhalation _____

Any other lung problems? _____

_____

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GASTROINTESTINAL

☐ Nausea _____ ☐ Belching _____ ☐ Rectal pain _____

☐ Vomiting _____ ☐ Black stools _____ ☐ Hemorrhoids _____

☐ Diarrhea _____ ☐ Blood in stools _____ ☐ Abdominal pain or cramps _____

☐ Constipation _____ ☐ Indigestion _____ ☐ Chronic laxative use _____

☐Gas _____ ☐ Bad breath _____

Any other problems with stomach or intestines? _____

GENITOURINARY

☐ Pain on urination _____ ☐ Urgency of urinate _____ ☐ Decrease in flow _____

☐ Frequent urination _____ ☐ Unable to hold urine _____ ☐ Impotence _____

☐ Blood in urine _____ ☐ Kidney stones _____ ☐ Sores on genitals _____

Do you wake up at night to urinate? _____

Any particular color to your urine? _____

Any other genital or urinary problems? _____

REPRODUCTIVE AND GYNECOLOGIC

☐ Premenstrual changes _____ ☐ Heavy menstrual flow _____

☐ Menstrual clots _____ ☐ Light menstrual flow _____

☐ Painful menses _____ ☐ Irregular menses _____ ☐ Abortions _____

☐ Unusual menses _____ ☐ Other problems _____

Age at first menses: _____ Age at first menopause: _____

Time between cycles: _____ Duration of bleeding: _____ First day of last menses: _____

Number of pregnancies: _____ Miscarriages: _____ Premature births: _____

Do you practice birth control? ____ If so, what type? _____ For how long? _____

Any other gynecologic problems? _____

_____

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MUSCULOSKELETAL

☐ Neck pain _____ ☐ Back pain _____ ☐ Hand/wrist pains _____

☐ Muscle pains _____ ☐ Muscle weakness _____ ☐ Shoulder pains _____

☐ Knee pain _____ ☐ Foot/ankle pains _____ ☐ Hip pain _____

Any other joint or bone problems? _____

_____

NEUROPHYSICAL

☐ Seizures _____ ☐ Poor memory _____ ☐ Anxiety _____

☐ Dizziness _____ ☐ Lack of coordination ____ ☐ Bad temper _____

☐ Loss of balance ____ ☐ Concussion _____ ☐ Easily susceptible to stress ___

☐ Areas of numbness _____ ☐ Depression _____

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

Any other neurological or psychological problems? _____

_____

COMMENTS

Please list any other problems you would like to discuss: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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INFORMED CONSENT FOR ACUPUNCTURE AND ORIENTAL MEDICINE

I hereby voluntarily consent to receive acupuncture and Oriental Medicine treatment for my present and future health condition. I understand that treatment will be administered by Tuan Anh Nguyen, licensed acupuncturist (L.Ac.), and/or Thuc-Dan Nguyen, licensed acupuncturist (L.Ac.). On occasion, if Tuan Anh Nguyen and/or Thuc-Dan Nguyen are not available, I consent to treatment by a substitute licensed acupuncturist as designated by Tuan Anh Nguyen and/or Thuc-Dan Nguyen and approved by myself. The treatments that will possibly be administered are described below.

Acupuncture and Oriental Medicine Treatments That May Be Administered

Acupuncture: This is a safe treatment involving the insertion of tiny sterile (and disposable) needles through the skin, which can produce a mild but temporary discomfort (usually achiness or soreness) at the acupuncture site. It can occasionally cause slight bleeding, and will rarely leave a bruise (not painful). Other possible risks from acupuncture include dizziness and fainting. I will report to the L.Ac. any dizziness or light-headedness that occur during or after an acupuncture treatment. Extremely rare risks of acupuncture (these have an extremely low incidence, especially when acupuncture is administered properly) include nerve damage, organ puncture, and infection.

Traditional Chinese Herbal Supplements: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of herbs, I understand that I should stop the herbs and that I am responsible for informing the L.Ac. of my symptoms. Some herbs may be inappropriate during pregnancy and breastfeeding. I accept full responsibility to inform the Licensed Acupuncturist of a suspected or confirmed pregnancy, or if I am a nursing mother.

Heat Treatment with a TDP Lamp: This is used to warm an area of the body. Every precaution is taken to prevent overwarming, but the rare possibility of mild burns exists.

Cupping: This involves a localized suction produced by a small plastic or glass cup. There is a possibility of local bruising from the suction which usually resolves within 3 – 7 days. Very rarely a slight burn or blisters may appear after the procedure.

Gua Sha: Gua Sha is scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising at the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

Plum Blossom (or tapping): Multiple, mild needle pricks on surface of skin. Slight bleeding at the area is likely, but not always.

Electro-Acupuncture: A mild electric micro-current (similar to a TENS treatment) is used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt.

By signing below, I show that:

__ I have read, or had read to me, the information on this consent form.

__ I understand the possible risks and complications involved. I have had the opportunity to discuss this consent form with my Licensed Acupuncturist. I understand that I can request more information at any time if desired.

__ I consent to receiving treatment that involves the above procedures.

__I understand that I have the right to refuse or discontinue any treatment at any time. I understand that this refusal may affect the expected results.

Patient Name (please print) _____

Patient Signature: _____ Date: _____

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Financial Policy

Thank you for selecting us to help taking care of your health. My staff and I are committed to your treatment being a positive experience. It is our firm belief that all people who entrust their health to us want and deserve the finest health care available. Please understand your financial obligations are considered part of your treatment. Our purpose in providing you this financial information is to acquaint you with our policy for our mutual benefit. We can give you an estimate of cost required in advance of treatment so that you can come prepared for each visit.

Below are our financial policy:

1. All payments for services will be collected at the end of each appointment. We accept cash, checks, and credit cards. A returned check fee is $35.00

2. Patients with Health Insurance will pay our fees at time treatment is rendered. We will provide you with the necessary information on a statement to be reimbursed by insurance; however, the patient / guarantor are responsible for payment of all charges.

If payment is not received from within 30 days, your balance will be subject to a finance charge of 2% per month. If your account becomes assigned to a collection agency, you agree to pay collection fees, court cost and attorney fees.

3. Your scheduled appointment time has been reserved at your request. If this time becomes inconvenient for you, please contact us at the office phone number, (703) 430-7058, at least 24 hours before the scheduled time. We do require this notification to offer this time to another patient in need. A $40.00 fee per each missed appointment will be charged to your account. Please help us avoid charging this fee by keeping your scheduled appointment.

4. If you are more than 15 minutes late we will have to reschedule your appointment, which will count as a broken appointment.

I have read and accept responsibility for the policies listed above

Signed _____ Date_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This notice summarizes how health data about you may be used and shared and how you can get access to this data.
INPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES.

I. How we may use and share health data about you:
a) Treatment – To give you medical treatment or other types of health services.
b) Payment – To bill you or a third party for payment for services provided to you.
c) Health Care Operations – For our own operations such as quality control, compliance monitoring, audit, etc.
II. Disclosures where we do not have to give you a chance to agree or object:
a) To you
b) As required by federal, state, or local law
c) If child abuse or neglect is suspected
d) Public health risk (for public health activities to prevent and control spread of disease)
e) Lawsuits and disputes (in response to a court and administrative order)
f) Law enforcement (to help law enforcement officials respond to criminal activities)
g) Coroners, medical examiners and funeral directors
h) Organ or tissue donation facilities if you are an organ donor
i) To avert a threat to an individual or to public health safety.
III. Disclosures where we have to give you a chance to agree or object:
a) Patient directories – You can decide what health data, if any, you want to be listed in patient directories.
b) Persons involved in your care or payment for your care – We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.
IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.
V. You have the following rights relating to the health data we keep about you:
a) Right to inspect your health record and to receive a copy of your health record upon request.
b) Right to amend information in your health record you believe is inaccurate or incomplete.
c) Right to know to whom we have disclosed your health information.
d) Right to ask for limits on the health information data we give out about you.
e) Right to receive communication from us about your health information in alternate ways.
f) Right to a paper copy of the complete Notice of Privacy Practices.

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

_____

Signature of patient or representative Date

_____

Print patient name