ACUPUNCTURE & HERB CLINIC, LLC. • 19420 Golf Vista Pl., Unit 230 • Leesburg, VA 20176 • (717) 357-2089

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 the line.

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

Today Date:_____________ Date of Birth: ____________ Age: ______

Marital Status:__________ Sex: ___ Email address:________________________________

Home Address: ____

City: _________________________________ State: ______________ Zip: ______________

Mailing Address (if Different):____

City: _________________________________ State: ______________ Zip: ________________

Phone: Home:_________________ Cell:_____________________ Work: __________________

Occupation: ___________________________ Employer's Name: ________________________

Employer's Address: ____

City: __________________________________ State: ______________ Zip: ________________

Spouse Name: _________________________ Employer: ____________________________

Other Physician's Name: ____

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

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

Welcome to our clinic! 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: _______ Height: ______ Weight: _______Lbs

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

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:____

____

____

____

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: _________________________________

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? ____

____

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? ____

____

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 L.Ac. 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 over-warming, but the rare possibility of mild burns exists.

Cupping: This involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction. Very rarely a slight burn or blister may appear due to the heat.

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 are applied in one area. 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 (or Guardian) Signature: ____ Date: ___________________

If a Guardian has signed, please print your name: ____

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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   Patient Birth Date