TCM Healing Points Acupuncture Clinic Registration Form/Health History Questionnaire

Personal Information:

Legal Name:__________________________________ Preferred Name: _______________________

Email: ________________________________

Phone # Home: _________________ Cell #: _________________ Receive Text Messages Yes No

Can we leave: detailed message _____ Appointment Confirmation _____

Address: ____

Street Number Street Apt # City State Zip Code

Occupation:_________________________________ Company Name: ___________________________

Emergency Contact:____________________ Relationship: ______________ Phone #: ______________

Gender: ________ Marital Status: _________ Date of Birth: ___/___/___ Age: _______

Have you had acupuncture before Yes No

Are you interested in taking herbs Yes No

I. Goals: What would you most like to achieve through your work at TCM Healing Points Acupuncture clinic?

1.____

2.____

3.____

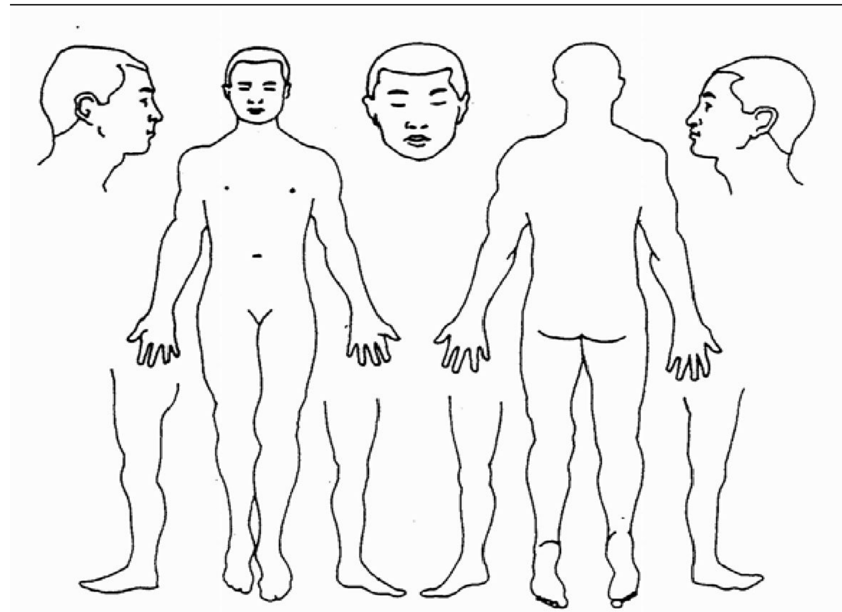
II. Major Symptoms: Please list in order of importance what symptoms are of concern to you.
(Most concerning to least, along with the duration of the symptom)

1.____

2.____

3.____

Use the following illustration to indicate painful or distressed areas:



XXX sharp/stabbing
PPP Pins & Needles
DDD Dull/ Aching
NNN Numbness

Are you experiencing pain/discomfort in any area of your body? Y/N

If yes, using the models above, please indicate the location of the discomfort by using the symbol that best describes the feeling.

For Women:

1. Are you pregnant now? [ ]Yes [ ]No [ ]Unsure
2. Indicate number of occurrences:

Live Births ______ Pregnancies______ Miscarriages ______

3. Age: First period ____ Menopause (if applicable) ____
4. Is your menses cycle regular? [ ] Yes [ ] No
   - a) Average number of days of flow _____
   - b) The flow is: [ ] Normal [ ] Heavy [ ] Light
   - c) The color is: [ ] Normal [ ] Dark [ ] Purple [ ] Light Brown [ ] Brown
5. Do you have the following menstruation related signs/symptoms?

[ ] Difficulty with orgasm [ ] Cramps [ ] PMS [ ] Heavy vaginal discharge between periods

[ ] Pain with Intercourse [ ] Nausea [ ] Bleeding between periods

[ ] Blood clots [ ] Breast Distention [ ] Vaginal discharge

For Men:

1. Do you have any bothersome urinary symptoms? [ ] Yes [ ] No

Describe: ____

2. Check all that apply:

[ ] Erectile dysfunction [ ] Difficulty with orgasm [ ]Pain/Swelling of testicles

[ ] Impotence/ erectile dysfunction [ ] Premature ejaculation [ ] Feeling of coldness/numbness in genitalia

[ ] Frequent need to urinate at night

3. Do you get up at night to urinate? [ ] Yes [ ] No How often? ______________________________
4. To what extent do these conditions interfere with your daily activities (work, sleep, socializing, etc.)?

____

III. Medical History

Please check all that apply	Date Diagnosed		Date Diagnosed
Diabetes	___/___/____	High Cholesterol	___/___/____
Heart Disease	___/___/____	High Blood Pressure	___/___/____
Thyroid Disease	___/___/____	Seizures	___/___/____
Cancer	___/___/____	Hepatitis	___/___/____
HIV	___/___/____	Others	___/___/____

IV. Surgical History

____ Date __________

____ Date __________

____ Date __________

____ Date __________

V. Family History

Please check all that apply and state how you are related to the family member with that condition

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Heart Disease					
Cancer					
Hypertension					
Stroke					
Asthma					
Allergies					
Migraines					
Depression					
Other Mental Illness					
Substance Abuse					
Osteoporosis					
Diabetes					
Glaucoma					

VI. Medications/ Supplements

Medications you are currently taking (please include prescription medicine, supplements, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Allergies (to medications, chemicals, or foods):

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

VIII. Nutrition

1. Do you follow a special diet? [ ] Yes [ ] No. If yes, how would you describe the diet?

(i.e. Vegetarian, Vegan, Low Carb, Low fat, ect.)

2.What do you eat on a "typical" day?

a) Breakfast ____

b) Lunch ____

c) Dinner ____

d) Snacks ____

e) Foods you tend to crave: ________________________________

f) Foods you dislike ________________________________

IX. Social History

1. How much per day do you use of the following?

a) Coffee, tea, soft drinks: ________________________________

b) Alcohol: ________________________________

c) Cigarettes, cigars, other tobacco: ________________________________

d) Other drugs: ________________________________

2. Have you ever had a problem with *alcohol* or *alcoholism*? [ ] Yes [ ] No

3. Have you ever had a problem with *dependency* on other drugs? [ ] Yes [ ] No

4. If yes which and when?

____

5. In the past year, how many days have been significantly affected by your health? __________

6. How many days did you feel generally poor? ______

7. How many times were you in the hospital? ______

8. Please describe your current exercise regimen:

Hours per week: _____ Activities: ______________________ [ ] No Exercise

9. How many hours of sleep do you usually get per night during the week? ________

10. Do you wake feeling rested? [ ] Yes [ ] No Do you feel you sleep well at night? [ ] Yes [ ] No

X. Other Information

Have you been treated for emotional issues? [ ] Yes [ ] No

Have you ever considered or attempted suicide? [ ] Yes [ ] No

Do you have any other neurological or psychological problem? [ ] Yes [ ] No

Please provide us with any other information that you think is relevant for us to know:

____

____

____

HEALTH: CHECK ALL THAT APPLY

GENERAL

Past	Current	Condition
[ ]	[ ]	Poor appetite
[ ]	[ ]	Excessive appetite
[ ]	[ ]	Insomnia
[ ]	[ ]	Fatigue
[ ]	[ ]	Fevers
[ ]	[ ]	Night Sweats
[ ]	[ ]	Sweat easily
[ ]	[ ]	Chills
[ ]	[ ]	Local weakness
[ ]	[ ]	Poor coordination
[ ]	[ ]	Bleed/bruise easy
[ ]	[ ]	Catch cold easily
[ ]	[ ]	Change in appetite
[ ]	[ ]	Strong Thirst

SKIN & HAIR

Past	Current	Condition
[ ]	[ ]	Rashes
[ ]	[ ]	Hives
[ ]	[ ]	Itching
[ ]	[ ]	Eczema
[ ]	[ ]	Pimples
[ ]	[ ]	Dryness
[ ]	[ ]	Tumors/Lumps

HEAD & NECK

Past	Current	Condition
[ ]	[ ]	Dizziness
[ ]	[ ]	Fainting
[ ]	[ ]	Neck stiffness
[ ]	[ ]	Enlarged lymph
[ ]	[ ]	Headaches
[ ]	[ ]	Concussion

EARS & Eyes

Past	Current	Condition
[ ]	[ ]	Infection
[ ]	[ ]	Ringing
[ ]	[ ]	Hearing loss
[ ]	[ ]	Spots in Eyes
[ ]	[ ]	Blurred Vision
[ ]	[ ]	Cataracts
[ ]	[ ]	Other ___________

NOSE, THROAT, MOUTH

Past	Current	Condition
[ ]	[ ]	Nose bleeds
[ ]	[ ]	Sinus Infection
[ ]	[ ]	Recurring sore throat
[ ]	[ ]	Grinding teeth
[ ]	[ ]	Difficulty swallowing

MALE

Past	Current	Condition
[ ]	[ ]	Pain/itching Genitalia
[ ]	[ ]	Genital lesions/discharge
[ ]	[ ]	Impotence
[ ]	[ ]	Weak urinary stream
[ ]	[ ]	Lumps in testicles

CARDIOVASCULAR

Past	Current	Condition
[ ]	[ ]	High blood Pressure
[ ]	[ ]	Low blood Pressure
[ ]	[ ]	Blood Clots
[ ]	[ ]	Palpitations
[ ]	[ ]	Phlebitis
[ ]	[ ]	Chest Pain
[ ]	[ ]	Irregular heartbeat
[ ]	[ ]	Cold hands/feet
[ ]	[ ]	Fainting
[ ]	[ ]	Difficult breathing
[ ]	[ ]	Swelling of hands/feet

RESPIRATORY

Past	Current	Condition
[ ]	[ ]	Asthma
[ ]	[ ]	Bronchitis
[ ]	[ ]	Frequent Colds
[ ]	[ ]	COPD
[ ]	[ ]	Pneumonia
[ ]	[ ]	Cough
[ ]	[ ]	Coughing blood
[ ]	[ ]	Production of phlegm
[ ]	[ ]	other _______________

GASTRO-INTESTINAL

Past	Current	Condition
[ ]	[ ]	Nausea
[ ]	[ ]	Vomiting
[ ]	[ ]	Diarrhea
[ ]	[ ]	Belching
[ ]	[ ]	Blood in stool/black
[ ]	[ ]	Bad breath
[ ]	[ ]	Rectal pain
[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Constipation
[ ]	[ ]	Pain or Cramps
[ ]	[ ]	Indigestion
[ ]	[ ]	Gallbladder disorder
[ ]	[ ]	Gas

GENITO-URINARY

Past	Current	Condition
[ ]	[ ]	Kidney stones
[ ]	[ ]	Pain on urination
[ ]	[ ]	Frequent urination
[ ]	[ ]	Blood in urine
[ ]	[ ]	Urgency to urinate
[ ]	[ ]	Unable to hold urine

FEMALE

Past	Current	Condition
[ ]	[ ]	Frequent UTI's
[ ]	[ ]	Frequent vaginal infections
[ ]	[ ]	Pain/Itching of genitalia
[ ]	[ ]	Genital lesions/ discharge
[ ]	[ ]	Pelvic inflammatory disease
[ ]	[ ]	Abnormal pap smear
[ ]	[ ]	Irregular menstrual periods
[ ]	[ ]	Painful menstrual periods
[ ]	[ ]	Premenstrual syndrome
[ ]	[ ]	Abnormal bleeding
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	breast lumps
[ ]	[ ]	Hot Flashes
[ ]	[ ]	Menopausal syndrome

NEUROLOGICAL

Past	Current	Condition
[ ]	[ ]	Seizures
[ ]	[ ]	Tremors
[ ]	[ ]	Numbness/ tingling of limbs
[ ]	[ ]	Concussion
[ ]	[ ]	Pain
[ ]	[ ]	Paralysis
[ ]	[ ]	Other ________________________

PSYCHOLOGICAL

Past	Current	Condition
[ ]	[ ]	Depression
[ ]	[ ]	Anxiety/ Stress
[ ]	[ ]	Irritability
[ ]	[ ]	Emotional problems
[ ]	[ ]	Other ________________________

INFECTION SCREENING

Past	Current	Condition
[ ]	[ ]	HIV
[ ]	[ ]	TB
[ ]	[ ]	Hepatitis
[ ]	[ ]	Gonorrhea
[ ]	[ ]	Syphilis
[ ]	[ ]	Genital Warts
[ ]	[ ]	Herpes: oral
[ ]	[ ]	

MUSCULAR-SKELETAL

Past	Current	Condition
[ ]	[ ]	Stiff neck/shoulders
[ ]	[ ]	Low back pain
[ ]	[ ]	Muscle spasm/cramps
[ ]	[ ]	Sore, cold or weak knees
[ ]	[ ]	Joint Pain

HIPAA SHORT FORM NOTICE OF PRIVACY PRACTICES for purposes of this Notice of Privacy Practices, "we" or "us" refers to TCM Healing Points Acupuncture clinic, Tiffiny Davis AP, and office staff. We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We created a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this clinic, weather made by your individual doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information. We are required by law to: give you this notice of our legal duties and privacy practices with respect to health information about you; make sure that healthinfromation that identifies you is kept private; and follow the terms of our HIPPA notice that is currently in effect at all times. How we may use, and disclose health information about you, in relation to, or as requested:

- Treatment
- Payment
- Healthcare operations
- Appointment reminders
- As required by law
- To advert a serious threat to health and safety
- Public health risks
- Health oversight activities

Law enforcement
Lawsuits and disputes
Coroners, Health examiners & Funeral Directors
National Security and Intelligence activities
Protective Services for the President and Others
Security officials for Inmates
As required by the Military, Veterans and
Workers Compensation

Your rights regarding Health Information about you, your right to :

- Inspect and copy
- Request Restrictions
- Amend
- An accounting of disclosure
- Request Confidential communications
- A paper copy of our full notice

Changes to this notice: we reserve the right to change this notice. We will post a copy of the current notice in our office with the current effective date on the first page. Complaints: if you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact Tiffiny Davis to file a complaint. Acknowledgement of receipt of this notice: we will request that you sign this acknowledgement and it will become part of your records. This acknowledgment provides that you have declined to accept the complete notice and instead requested this short form.

____ ________________

Print full legal name Date

____ ________________

Patient Signature or Legal Guardian Date

Payment Policy Agreement:

I ______________________________, understand that I am responsible for payment of service rendered at the time of treatment unless payment is approved by your insurance company or prior arrangements have been made for a different payment agreement.   I also understand that I am responsible for any remaining balance that is not paid by my insurance company. I also understand and agree to a charge of $30 for cancellation of an appointment less than 24 hours in advance of the scheduled treatment time, unless a valid reason is cause for cancellation. This fee will be charged to the credit card or debit card that will be on file.

CREDIT CARD ON FILE POLICY

At TCM Healing Points Acupuncture Clinic, we require keeping your credit or debit card on file as a method of payment for cancellations made less than 24 hours and/or missed appointments.

Your credit card information is kept confidential and secure and payments to your card are only processed if you miss an appointment or fail to notify Family Acupuncture and Wellness Clinic at least 24 hours in advance of your appointment.

I, __________________ authorize Tiffiny Davis A.P of TCM Healing Points Acupuncture Clinic to charge a $30.00 fee for the missed acupuncture treatment to the following credit or debit card:

☐ Amex ☐ Visa ☐ Mastercard ☐ Discover

Credit Card Number ____

Expiration Date ____ / ____ / ____

Cardholder Name ____

Signature ____

Billing Address ____

City _________________ State______ Zip _________

I , the undersigned, authorize Tiffiny Davis A.P from TCM Healing Points Acupuncture Clinic to charge my credit card, indicated above, for balances due for missed or late cancelled appointments.

This authorization relates to all payments for missed or last minute cancellations as stated and signed by me in the TCM Healing Points Acupuncture Clinic office policies

Patient Name (Print): _____________________________________

Patient Signature: _______________________________________

Date Signed:____________

INFORMED CONSENT FOR TREATMENT

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

Purpose of Treatment: The purpose of the treatment is to resolve your complaint, i.e. the reason you are seeking treatment. Acupuncture is a health care service that is based on an Oriental system of medical theory. Diagnosis and treatment, based on these theories are used to promote health and treat organic or functional disorders.

Benefit of Treatment: Acupuncture and Oriental Medicine procedures have been used effectively to treat disease for hundreds of years. The World Health organization lists 43 conditions, which may effectively be treated by Chinese medical methods. These include muscular-skeletal injuries, digestive disorders, respiratory diseases, women's health issues, etc. We cannot guarantee the outcome of any course of treatment.

Risks of Treatment: Acupuncture and Oriental medicine have been shown to be relatively safe. However, these are some uncommon but potential risks. These potential risks may include but are not limited to:
-Discomfort during and after the insertion of a needle
-"Needle sickness" (dizziness, fainting, nausea)
-Localized, minor bruising or swelling
-Minor burns with the use of Moxa
-Gastro-intestinal upset with the use of Chinese herbs (if this occurs, please consult with your practitioner so that your formula can be modified)
-Possible, temporary aggravation of symptoms that existed prior to treatment
-Pneumothorax
-A broken needle (rare with the use of disposable needles)

Special Situations: Some herbs and acupuncture points are contra-indicated during pregnancy. Please notify us if you might be pregnant. Additionally, please inform us if you have severe bleeding disorders or if you are wearing a pacemaker or other electronic medical device.

Consent
I request and consent to the performance of acupuncture and this Oriental Medicine procedure. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time. I understand that my signature in this form indicates that I have read and understand the preceding information regarding my treatment. I understand that if I have any questions about this information, I should ask my acupuncturist. I, hereby release TCM Healing Points Acupuncture Clinic from any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

Patient's name (Please print)

____Date_____________

Patient's Signature____