

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

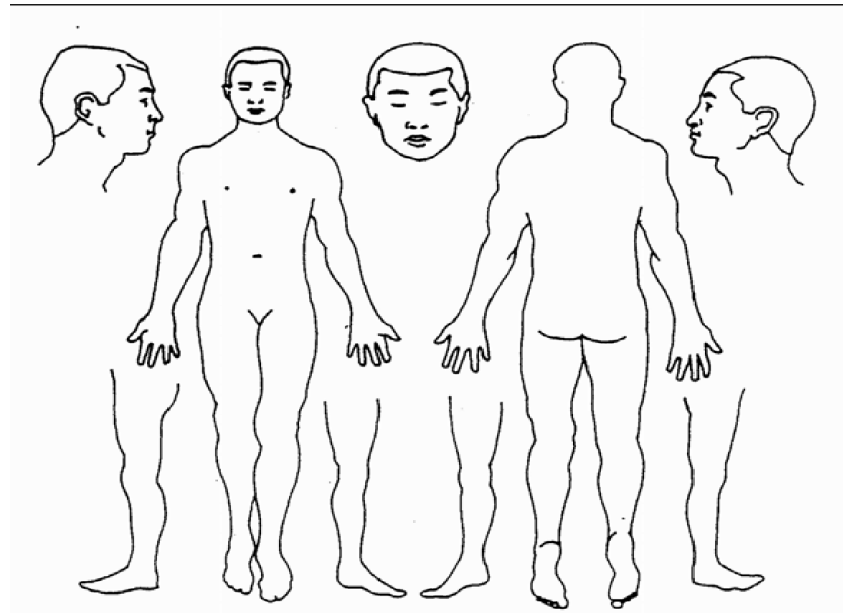
I. Goals: What would you most like to achieve through your work at TCM Healing Points Acupuncture clinic?

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 problems? [] Yes [] No

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

HEALTH: CHECK ALL THAT APPLY

GENERAL

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite
<input type="checkbox"/>	<input type="checkbox"/>	Excessive appetite
<input type="checkbox"/>	<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Fevers
<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats
<input type="checkbox"/>	<input type="checkbox"/>	Sweat easily <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Chills
<input type="checkbox"/>	<input type="checkbox"/>	Local weakness
<input type="checkbox"/>	<input type="checkbox"/>	Poor coordination
<input type="checkbox"/>	<input type="checkbox"/>	Bleed/bruise easy
<input type="checkbox"/>	<input type="checkbox"/>	Catch cold easily
<input type="checkbox"/>	<input type="checkbox"/>	Change in appetite
<input type="checkbox"/>	<input type="checkbox"/>	Strong Thirst

CARDIOVASCULAR

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	High blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Low blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots
<input type="checkbox"/>	<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heartbeat <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Cold hands/feet
<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Difficult breathing
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of hands/feet

FEMALE

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Frequent UTI's
<input type="checkbox"/>	<input type="checkbox"/>	Frequent vaginal infections
<input type="checkbox"/>	<input type="checkbox"/>	Pain/Itching of genitalia
<input type="checkbox"/>	<input type="checkbox"/>	Genital lesions/ discharge
<input type="checkbox"/>	<input type="checkbox"/>	Pelvic inflammatory disease
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal pap smear
<input type="checkbox"/>	<input type="checkbox"/>	Irregular menstrual periods
<input type="checkbox"/>	<input type="checkbox"/>	Painful menstrual periods
<input type="checkbox"/>	<input type="checkbox"/>	Premenstrual syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Menopausal syndrome
<input type="checkbox"/>	<input type="checkbox"/>	breast lumps
<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes
<input type="checkbox"/>	<input type="checkbox"/>	Menopausal syndrome

SKIN & HAIR

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Rashes
<input type="checkbox"/>	<input type="checkbox"/>	Hives
<input type="checkbox"/>	<input type="checkbox"/>	Itching
<input type="checkbox"/>	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	<input type="checkbox"/>	Pimples
<input type="checkbox"/>	<input type="checkbox"/>	Dryness
<input type="checkbox"/>	<input type="checkbox"/>	Tumors/Lumps

RESPIRATORY

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds
<input type="checkbox"/>	<input type="checkbox"/>	COPD
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Cough
<input type="checkbox"/>	<input type="checkbox"/>	Coughing blood
<input type="checkbox"/>	<input type="checkbox"/>	Production of phlegm
<input type="checkbox"/>	<input type="checkbox"/>	other _____

NEUROLOGICAL

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Tremors
<input type="checkbox"/>	<input type="checkbox"/>	Numbness/ tingling of limbs
<input type="checkbox"/>	<input type="checkbox"/>	Concussion
<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

HEAD & NECK

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Neck stiffness
<input type="checkbox"/>	<input type="checkbox"/>	Enlarged lymph
<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Concussion

GASTRO-INTESTINAL

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Belching
<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool/black
<input type="checkbox"/>	<input type="checkbox"/>	Bad breath
<input type="checkbox"/>	<input type="checkbox"/>	Rectal pain
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Pain or Cramps
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder disorder
<input type="checkbox"/>	<input type="checkbox"/>	Gas

PSYCHOLOGICAL

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/ Stress
<input type="checkbox"/>	<input type="checkbox"/>	Irritability
<input type="checkbox"/>	<input type="checkbox"/>	Emotional problems
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

EARS & Eyes

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Infection
<input type="checkbox"/>	<input type="checkbox"/>	Ringing
<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss
<input type="checkbox"/>	<input type="checkbox"/>	Spots in Eyes
<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

GENITO-URINARY

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones
<input type="checkbox"/>	<input type="checkbox"/>	Pain on urination
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	Urgency to urinate
<input type="checkbox"/>	<input type="checkbox"/>	Unable to hold urine

INFECTION SCREENING

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	HIV
<input type="checkbox"/>	<input type="checkbox"/>	TB
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea
<input type="checkbox"/>	<input type="checkbox"/>	Syphilis
<input type="checkbox"/>	<input type="checkbox"/>	Genital Warts
<input type="checkbox"/>	<input type="checkbox"/>	Herpes: oral
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

NOSE, THROAT, MOUTH

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Infection
<input type="checkbox"/>	<input type="checkbox"/>	Recurring sore throat
<input type="checkbox"/>	<input type="checkbox"/>	Grinding teeth
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing

MUSCULAR-SKELETAL

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Stiff neck/shoulders
<input type="checkbox"/>	<input type="checkbox"/>	Low back pain
<input type="checkbox"/>	<input type="checkbox"/>	Muscle spasm/cramps
<input type="checkbox"/>	<input type="checkbox"/>	Sore, cold or weak knees
<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain

MALE

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Pain/itching Genitalia
<input type="checkbox"/>	<input type="checkbox"/>	Genital lesions/discharge
<input type="checkbox"/>	<input type="checkbox"/>	Impotence
<input type="checkbox"/>	<input type="checkbox"/>	Weak urinary stream
<input type="checkbox"/>	<input type="checkbox"/>	Lumps in testicles

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, Tiffany 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, whether 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 health information that identifies you is kept private; and follow the terms of our HIPAA 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 | Law enforcement |
| ● Payment | Lawsuits and disputes |
| ● Healthcare operations | Coroners, Health examiners & Funeral Directors |
| ● Appointment reminders | National Security and Intelligence activities |
| ● As required by law | Protective Services for the President and Others |
| ● To avert a serious threat to health and safety | Security officials for Inmates |
| ● Public health risks | As required by the Military, Veterans and |
| ● Health oversight activities | 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 Tiffany 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. I also understand and agree to a charge of \$75 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. If no information is provided below, payment for missed appointments will be collected at the next appointment.

Patient Signature or Legal Guardian

Date

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 TCM Healing Points Acupuncture Clinic at least 24 hours in advance of your appointment.

I, _____ authorize Tiffany 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 Tiffany Davis A.P from TCM Healing Points Acupuncture Clinic to charge my credit card, indicated above, for balances due for missed or late canceled 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 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 on 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 _____