Patty Johnson's
Acupuncture and Herbs

NEW PATIENT REGISTRATION & HEALTH HISTORY

Basic Information

Best method to send appointment reminders ☐ Phone ☐ text ☐ eMail

Patient Name Sex: ☐ M ☐ F	Social Security #		Date of Birth	
Address	Marital Status	# of Children	Height	Weight
City, State & Zip	Mobile Phone #		Home Phone #	
eMail Address Would you like to receive our newsletter? ☐ Y ☐ N	Whom may we thank for your referral?			
Emergency Contact Name	Emergency Contact Phone #		Relation to Emergency Contact	

Employment Information Text

☐ Employed ☐ Student ☐ Other:

Employer Name	Employer Phone #	Professional Title
Address	City, State & Zip	

Accident Information

Is condition due to an accident? ☐ Y ☐ N

Date of Accident	Type of Accident ☐ Auto ☐ Work ☐ Other:	Claim #
To whom did you report accident?	Adjuster's Name	Phone #

Health Insurance Information

Insurance Company Name	Name Responsible for Account	Group #	Claim/ID #
Other Insurance Company Name	Name Responsible for Account	Group #	Claim/ID#

Which of the following have you tried before?				
☐ Acupuncture	☐ Acupressure, Tui-Na	☐ Herbal Medicine	☐ Cosmetic Acupuncture	☐ Weight Loss
☐ Chiropractic	☐ Physiotherapy/Rehab	☐ Kinesio-taping	☐ Nutritional Analysis	☐ Essential Oils
Which of the following are you interested in hearing more about?				
☐ Acupuncture	☐ Acupressure, Tui-Na	☐ Herbal Medicine	☐ Cosmetic Acupuncture	☐ Weight Loss
☐ Chiropractic	☐ Physiotherapy/Rehab	☐ Kinesio-taping	☐ Nutritional Analysis	☐ Essential Oils

Assignment & Release Statement

I certify that if I, and/or my dependent(s), have insurance coverage, I shall assign to Patty Johnson's Acupuncture and Herbs and/or its affiliates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature or all insurance submissions. I also understand that sending in my insurance claim is a courtesy and not a requirement. Patty Johnson's Acupuncture and Herbs and its affiliates/agents may use my health care information and may disclose such information to the health care insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I have read the privacy practices of this practice. I intend this consent to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due.

Patient/Guardian Signature Date

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Patient Health History

Please identify the health concerns that have brought you here in order of importance

Conditions(s)	Past Treatment
What caused your symptoms to start?	

When did symptom(s) appear?	Condition is Getting ☐ Better ☐ Worse ☐ Same ☐ Don't know	Has it occurred before? ☐ Y ☐ N If yes, when?	Additional Comments

Sensation Types

Please mark appropriate symbols on the diagrams

X Sharp, Stabbing, Burning

> Shooting, Radiating

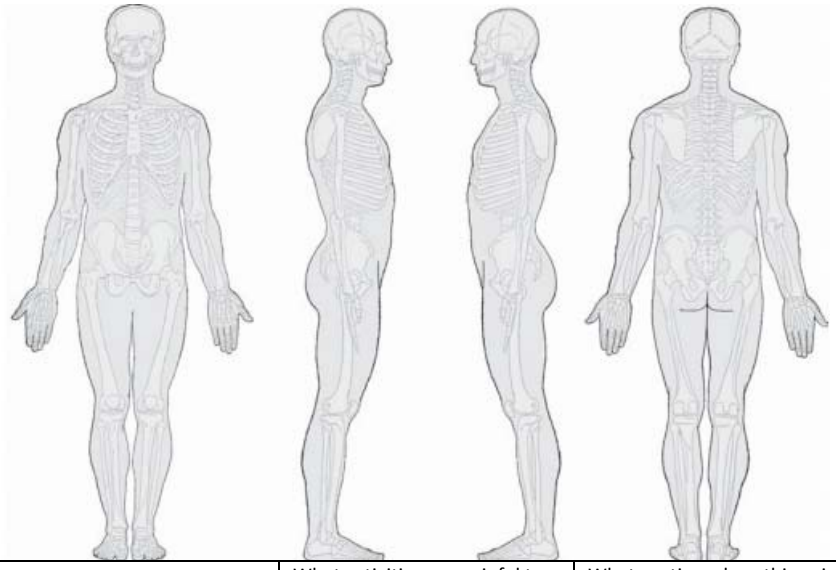
N Numbness, Tingling

O Edema, Swelling

A Dull, Achy

T Throbbing

Other _____



Pain Level – 1 = No Pain, 10 = Most Pain

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Date of Last Physical Exam	Health ☐ Excellent ☐ Good ☐ Fair ☐ Poor			
What percentage of time do you experience this problem? ☐ <25% ☐ 75% ☐ 25% ☐ 100% ☐ 50%	What relieves the pain? ☐ Heat ☐ Cold ☐ Massage ☐ Rest ☐ Exercise ☐ Other:	What makes the pain worse? ☐ Weather ☐ Heat ☐ Cold ☐ Movement ☐ Other:	What activities are painful to perform? ☐ Lying ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Other:	What routines does this pain interfere with? ☐ Work ☐ Sleep ☐ Recreation ☐ Other:

Allergies – List any foods, drugs, or medications and include reaction

Medication – List any medications, vitamins, and supplements you are currently taking and why

Family History – If any blood relative has the following conditions, check and indicate which relative

☐ Alcoholism	_____	☐ Cancer	_____	☐ High Blood Pressure	_____
☐ Anemia	_____	☐ Diabetes	_____	☐ High Cholesterol	_____
☐ Arteriosclerosis	_____	☐ Emphysema	_____	☐ Multiple Sclerosis	_____
☐ Arthritis	_____	☐ Epilepsy	_____	☐ Osteoporosis	_____
☐ Asthma	_____	☐ Glaucoma	_____	☐ Stroke	_____
☐ Bleeding	_____	☐ Heart Disease	_____	☐ Thyroid Disease	_____

Other:

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NEW PATIENT REGISTRATION & HEALTH HISTORY

Previous Injuries, Surgeries & Hospitalizations

List each occurrence and date

Car Accidents
Other Injuries/Fractures/Falls
Surgeries
Hospitalizations
Xrays/MRIs/CT scans
Other Studies/Blood Tests

Lifestyle

Habits

Meals per day _____ Do you snack often? ☐ Y ☐ N Smoking - Packs per Day _____ Soft Drinks per Day _____ Water - Cups per Day _____

Hours of Sleep per Day _____ Do you wake rested? ☐ Y ☐ N Alcoholic Drinks per Day _____ Coffee - Cups per Day _____ Tea - Cups per Day _____

Exercise ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Work Activity ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Check all that you have had:

☐ Alcoholism
☐ Anemia
☐ Appendicitis
☐ Arteriosclerosis
☐ Asthma
☐ Bronchitis
☐ Cancer
☐ Chicken pox
☐ Cold sores
☐ Diabetes
☐ Eczema
☐ Edema
☐ Emphysema
☐ Epilepsy
☐ Goiter
☐ Gout
☐ Heart burn
☐ Heart disease
☐ Hepatitis
☐ Herpes
☐ High cholesterol
☐ HIV/AIDS
☐ Influenza
☐ Malaria
☐ Measles
☐ Miscarriage
☐ Multiple sclerosis
☐ Numbness/tingling
☐ Pace maker
☐ Osteoporosis
☐ Pneumonia
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis
☐ Ulcers

Check all that you have or are experiencing:

General
☐ Allergies
☐ Depression
☐ Dizziness
☐ Fainting
☐ Fatigue
☐ Fever
☐ Headaches
☐ Loss of sleep
☐ Mental illness
☐ Nervousness
☐ Tremors
☐ Weight loss/gain

Muscle/Joint
☐ Arthritis/Rheumatism
☐ Bursitis
☐ Foot trouble
☐ Low back pain
☐ Neck pain
☐ Mid back pain
☐ Joint pain

Skin
☐ Boils
☐ Bruise easily
☐ Dryness
☐ Hives or allergies
☐ Itching
☐ Rash
☐ Varicose veins

Urination
☐ Overnight >2x
☐ More than 8x in 24hrs
☐ Decreased flow/force
☐ Painful urination
☐ Urgency to urinate

Eye, Ear, Nose & Throat
☐ Colds
☐ Deafness
☐ Ear ache
☐ Eye pain
☐ Gum trouble
☐ Hoarseness
☐ Nasal obstruction
☐ Nose bleeds
☐ Ringing of the ears
☐ Sinus infection
☐ Sore throat
☐ Tonsillitis
☐ Vision problems

Genitourinary
☐ Bed-wetting
☐ Bladder infection
☐ Blood in urine
☐ Kidney infection
☐ Kidney stones
☐ Prostate trouble
☐ Pus in urine
☐ Stress incontinence

Cardiovascular
☐ High Blood pressure
☐ Low blood pressure
☐ Hardening of arteries
☐ Irregular pulse
☐ Pain over heart
☐ Palpitation
☐ Poor circulation
☐ Rapid heart beat
☐ Slow heart beat
☐ Swelling of ankles

Gastrointestinal
☐ Abdominal pain
☐ Bloody/tarry stools
☐ Colitis/Crohn's
☐ Colon trouble
☐ Constipation
☐ Diarrhea
☐ Digestive difficulty
☐ Diverticulitis
☐ Bloated abdomen
☐ Excessive hunger
☐ Gallbladder trouble
☐ Hernia
☐ Hemorrhoids
☐ Intestinal worms
☐ Jaundice
☐ Liver trouble
☐ Nausea
☐ Painful defecation
☐ Pain over stomach
☐ Poor appetite
☐ Vomiting food/blood

Respiratory
☐ Chest pain
☐ Chronic cough
☐ Difficulty breathing
☐ Hay fever
☐ Shortness of breath
☐ Spitting up phlegm/blood
☐ Wheezing

Women Only
☐ Congested breasts
☐ Hot flashes
☐ Lumps in breast
☐ Menopause
☐ Vaginal discharge

Menstrual
☐ Regular ☐ Irregular
☐ Painful ☐ Cramps
☐ Back pain ☐ Headaches
☐ Breast pain ☐ Mood swings
# of days _____
Length of cycle _____
1st day last period _____
Color of menses _____
Clotting ☐ Y ☐ N
Sticky ☐ Y ☐ N
Hysterectomy ☐ Y ☐ N
Vaginal discharge ☐ Y ☐ N
Premenopausal ☐ Y ☐ N

Are you pregnant? ☐ Y ☐ N
If yes, # of months _____

Birth control method _____

Date of last PAP test _____
☐ Normal ☐ Abnormal

Date of last Mammogram _____
☐ Normal ☐ Abnormal

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NEW PATIENT REGISTRATION & HEALTH HISTORY

Informed Consent & Patient's Bill of Rights

I hereby authorize the staff of Patty Johnson's Acupuncture and Herbs and its affiliates to conduct examinations, acupuncture treatments and other procedures necessary, including but not limited to various modalities of physiotherapy, soft-tissue techniques, cupping, tui-na, and electro-acupuncture on me or on the patient for whom I am legally responsible. The practice of medicine and acupuncture is not an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases. I understand that in the practice of medicine and acupuncture, there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the staff of Patty Johnson's Acupuncture and Herbs and its affiliates to be able to anticipate and explain all risks and complications. I wish to rely on the practitioner and/or staff to exercise judgment during the course of the procedures which (s)he feels at the time, based on the fact then known, are in my best interests. I have discussed verbally with acupuncturist and/or with other office or clinic personnel the nature and purpose of acupuncture related procedures that may be used in my treatment. I have read the information below and understand the possible risk involved. I may request another person of my choice to be present in the treatment room during treatment.

Acupuncture is a safe and effective method of treatment which involves the insertion of needles through the skin. However, it can occasionally cause slight bleeding that usually resolves with pressing dry cotton on the spot where the skin is bleeding. It is also normal for the patient to have a temporary warm, tight, sore or tingling sensation at the acupuncture site. **Acupressure/TuiNa** involves rubbing, kneading, pressing, and stroking, etc., which may result in muscle soreness at the massage site that can last several days. This technique may require disrobing. I understand all attempts will be made to assure my privacy. **Cupping** involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction and slight burning or blistering due to the heat involved in the technique. **Gua Sha** involves scraping over a small area by using a smooth-edged instrument. There is a possibility that local bruising is likely to occur at the site where Gua Sha is performed. **Tapping, Plum Blossom, Bleeding, Pricking** all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment site is a likely occurrence. **Electrical Stimulation/TENS** uses microcurrent electricity to stimulate acupuncture points. A mild tingling sensation of electricity will be felt. I am aware that certain adverse side effects may result from any of the above. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment.

Herbal/Nutritional supplements: The herbs and nutritional supplements (which are from plants, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine and Acupuncture I understand that some herbs may be inappropriate during pregnancy. If I experience any gastro-intestinal upset or allergic reactions to the herbs I will inform my treating physician. I understand that there are no returns/exchange on opened supplements.

I understand that no guarantees to treatment efficacy and that I am free to stop treatment at any time. I understand that there may be other treatment alternatives and I have the right to refuse or discontinue treatment at anytime. This refusal may affect the expected results. I have read, or have had read to me, the above consent. I agree to the above, and allow the staff of Patty Johnson's Acupuncture and Herbs and its affiliates to perform such procedures. I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

Patient has the right to: a considerate and respectful care and is encouraged to obtain from physicians and other direct caregivers relevant, current, and understandable information concerning diagnosis, treatment, and prognosis; the opportunity to discuss & request information related to specific procedures and/or treatments, risks involved, possible length of recuperation, and medically reasonable alternatives and their accompanying risks and benefits; know identity of providers, the financial implications of treatment choices, insofar as they are known; make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care. The patient also has the right to be informed of the medical consequences of this action. In case of such refusal, the patient is entitled to other appropriate care and services; privacy (discussion, consultation, examination, & treatment should be conducted to protect each patient's privacy); expect that all communications and records pertaining to his/her care will be treated confidentially, except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law. The patient has the right to expect that the provider will emphasize the confidentiality of this information when it releases it to any other parties entitled to review information in these records; review the records pertaining to his/her medical care and to have the information explained or interpreted as necessary, except when restricted by law; expect that, within its capacity & policies, a provider will make reasonable response to patient's request for appropriate/ medically indicated care & services. Provider must provide evaluation, service, and/or referral as needed. The patient will be informed of the existence of business relationships among the provider, other health care providers, or payers that may influence the patient's treatment and care; consent to or decline to participate in proposed research studies or human experimentation affecting care & treatment or requiring direct patient involvement, and to have those studies fully explained prior to consent. Patient has the right to be informed of available resources for resolving disputes, grievances, and conflicts. Patient has the right to be informed of the provider's charges for services and available payment methods. Collaborative nature of healthcare requires that patients/their families/surrogates, participate in their care. Effectiveness of care & patient satisfaction with the course of treatment depend, in part, on the patient fulfilling certain responsibilities. Patients are responsible for providing information about past illnesses, hospitalizations, medications, and other matters related to health status. To participate effectively in decision making, patients must be encouraged to take responsibility for requesting additional information or clarification about their health status or treatment when they do not fully understand information & instructions. Patients are responsible for informing their providers and other caregivers if they anticipate problems in following prescribed treatment. Patients should also be aware of the provider has to be reasonably efficient and equitable in providing care to other patients and the community. Patients and their families are responsible for making reasonable accommodations to the needs of the provider, other patients, staff, and employees. Patients are responsible for providing necessary information for insurance claims, when necessary. A person's health depends on more than healthcare service. Patients are responsible for recognizing impact of their life-style on their personal health.

Cancellation/No Show Policy

We reserve your appointment time for you and we expect you to keep all your appointments with the exception of serious emergencies. If you need to re-schedule or cancel an appointment we require 24 hours notice. There is a automatic $25.00 fee for late cancellation and no-shows. In instances of repeated non-compliance, we reserve the right to discontinue care.

_____
initial

I certify that information on these forms has been answered truthfully and completely to the best of my knowledge. I have read the informed consent, bill of rights, and privacy statement.

_____ _____
Patient/Guardian Signature Date