

**WEI'S CHINESE MEDICAL CENTER**  
**CONTACT INFORMATION**

Today's Date: \_\_\_ / \_\_\_ / \_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Sex:  F  M DOB \_\_\_ / \_\_\_ / \_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_

Marital Status:  M  S  D  W

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Telephone – Home: \_\_\_\_\_ Preferred: (circle: Home Cell Work)

Other: Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Do we have your permission to send appointment reminders, health newsletters, and occasional promotions to your email address?

Yes \_\_\_\_\_ No \_\_\_\_\_

We will not sell or give your email to any other agency.

**Email Address:** \_\_\_\_\_

Emergency Contact:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Relationship: \_\_\_\_\_

How did you find out about us?

Direct Mail  Location or Walk By  Friend/Relative  Website  Periodicals

Yellow Pages  Other

Referred By: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ ID #: \_\_\_\_\_

Group #: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Parent

Customer Service Phone Number: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_

Group #: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Parent

Customer Service Phone Number: \_\_\_\_\_

**Chief Complaint:** \_\_\_\_\_

How long? \_\_\_\_\_ How often: \_\_\_\_\_

What caused this (accident, lifestyle, drug, etc.)? \_\_\_\_\_

Describe the worst it can be: \_\_\_\_\_

What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other? \_\_\_\_\_

Get temporary relief? \_\_\_\_\_ Fixes your problem? \_\_\_\_\_ Causes side effects? \_\_\_\_\_

Affect your family? \_\_\_\_\_ Affect your sleep? \_\_\_\_\_

Affect your work? \_\_\_\_\_ Affect your hobbies? \_\_\_\_\_

What is your goal/plan if the problem continues 5/10/20 years? \_\_\_\_\_

**Complaint #2:** \_\_\_\_\_

How long? \_\_\_\_\_ How often: \_\_\_\_\_

What caused this (accident, lifestyle, drug, etc.)? \_\_\_\_\_

Describe the worst it can be: \_\_\_\_\_

What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other? \_\_\_\_\_

Get temporary relief? \_\_\_\_\_ Fixes your problem? \_\_\_\_\_ Causes side effects? \_\_\_\_\_

Affect your family? \_\_\_\_\_ Affect your sleep? \_\_\_\_\_

Affect your work? \_\_\_\_\_ Affect your hobbies? \_\_\_\_\_

What is your goal/plan if the problem continues 5/10/20 years? \_\_\_\_\_

**Complaint #3:** \_\_\_\_\_

How long? \_\_\_\_\_ How often: \_\_\_\_\_

What caused this (accident, lifestyle, drug, etc.)? \_\_\_\_\_

Describe the worst it can be: \_\_\_\_\_

What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other? \_\_\_\_\_

Get temporary relief? \_\_\_\_\_ Fixes your problem? \_\_\_\_\_ Causes side effects? \_\_\_\_\_

Affect your family? \_\_\_\_\_ Affect your sleep? \_\_\_\_\_

Affect your work? \_\_\_\_\_ Affect your hobbies? \_\_\_\_\_

What is your goal/plan if the problem continues 5/10/20 years? \_\_\_\_\_

**Other Complaints:** \_\_\_\_\_

<p>On a scale of 1-10, rate your commitment to get rid of the problem(s) and feel better _____</p> <p>Have you had acupuncture before? _____</p> <p>If yes, where/who _____</p> <p>Any concerns or fears about the needles? _____</p> <p>If yes, what? _____</p> <p>What are your goals of your acupuncture visits?</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>	<p><b><u>MEDICAL CONDITIONS</u></b> Please List conditions &amp; surgeries you have had and year diagnosed.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%;"></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> </table>									<p><b><u>ALLERGIES</u></b> Medications, Seasonal, Environmental, Food.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%;"></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> </table>								

**MEDICATIONS** – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops and nose sprays. NOTE: If need more space, use page 4.

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

**For each symptom you currently have, rate its severity from 1- 5 (5 being the worst).**  
**LEAVE BLANK IF NOT APPLICABLE**

<p><b><i>LIVER / GALLBLADDER</i></b></p> <p>_____ Irritability / Anger</p> <p>_____ Depression / Stress</p> <p>_____ Headaches / Migraines</p> <p>_____ Visual Problems</p> <p>_____ Red / Dry / Itchy Eyes</p> <p>_____ Gall Stones</p> <p>_____ Dizziness</p> <p>_____ Blurred Vision</p> <p>_____ Feeling of Lump in Throat</p> <p>_____ Clenching of Teeth at Night</p> <p>_____ Muscle Cramping / Twitching</p> <p>_____ Tension</p> <p>_____ Joints/Neck/Shoulder Pain/Tight</p> <p>_____ Poor Circulation</p> <p>_____ Soft / Brittle Nails</p> <p>_____ Emotional Eater</p> <p><b><i>KIDNEY / URINARY BLADDER</i></b></p> <p>_____ Urinary Problems</p> <p>_____ Bladder Infection</p> <p>_____ Lack of Bladder Control</p> <p>_____ Weakness / Pain in Lower Back</p> <p>_____ Decrease Bone Density</p> <p>_____ Feel Cold Easily</p> <p>_____ Low Sex Drive</p> <p>_____ Excess Sexual Desire</p> <p>_____ Poor Memory</p> <p>_____ Loss of Hair</p> <p>_____ Hearing Problems</p> <p>_____ Cavities</p> <p>_____ Craving / Avoiding Salty Foods</p> <p>_____ Fear</p> <p>_____ Hot Flush / Night Sweating</p>	<p><b><i>HEART / SMALL INTESTINES</i></b></p> <p>_____ Heart Palpitations</p> <p>_____ Chest Pain</p> <p>_____ Insomnia / Sleep Problems</p> <p>_____ Easily Startled</p> <p>_____ Restlessness / Agitation</p> <p>_____ Vivid Dreams</p> <p>_____ Lack of Joy in Life</p> <p><b><i>LUNG / LARGE INTESTINE</i></b></p> <p>_____ Dry Cough</p> <p>_____ Cough with Sputum</p> <p>_____ Nasal Discharge</p> <p>_____ Post-Nasal Drip</p> <p>_____ Sinus Infection / Congestion</p> <p>_____ Itchy, Red or Painful Throat</p> <p>_____ Dry Mouth / Throat / Nose</p> <p>_____ Skin Rashes / Hives</p> <p>_____ Snoring</p> <p>_____ Grief / Sadness</p> <p>_____ Shortness of Breath</p> <p>_____ Allergies / Asthma</p> <p>_____ Low Resistance to Colds or Flu</p> <p>_____ Sneezing</p> <p>_____ Mild Fever Comes &amp; Goes</p> <p>_____ Smoke Cigarettes</p> <p><b><i>BODY TEMPERATURE</i></b> <i>Please check all the apply:</i></p> <p>_____ Cold entire body</p> <p>_____ Cold extremities</p> <p>_____ Hot all day</p> <p>_____ Hot only in afternoon</p> <p>_____ Hot only at night</p> <p>_____ Normal</p>	<p><b><i>SPLEEN / STOMACH</i></b></p> <p>_____ Heaviness Anywhere in Body</p> <p>_____ Fatigue / Worse After Eating</p> <p>_____ Hard to Get Up in the Morning</p> <p>_____ Edema (Swelling)</p> <p>_____ Muscles Feel Tired Often</p> <p>_____ Easily Bruising &amp; Bleeding</p> <p>_____ Bad Breath</p> <p>_____ Decreased / Increased Appetite</p> <p>_____ Crave Sweets</p> <p>_____ Hypoglycemia</p> <p>_____ Difficulty Digesting Oily Foods</p> <p>_____ Nausea / Vomiting</p> <p>_____ Gas / Belching</p> <p>_____ Insulin Sensitivity</p> <p>_____ Hemorrhoids</p> <p>_____ Constipation</p> <p>_____ Diarrhea</p> <p>_____ Abdominal Pain</p> <p>_____ Indigestion / Heartburn</p> <p>_____ Over-Thinking</p> <p>_____ Tendency to Gain Weight</p> <p>_____ Brain Foggy</p> <p><b><i>ENERGY LEVEL – Please circle:</i></b> Low 1 2 3 4 5 6 7 8 9 10 High</p>
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## PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a “C” under the appropriate person’s column. “P” should be used to indicate a past problem. Leave blank those that do not apply. If you require more space, use the reverse side of this form.

<i>Age</i>	You	Father	Mother	Spouse	Brother(s)	Sister(s)	Children
AIDS / HIV							
Alcohol							
Anxiety							
Arthritis							
Asthma / Hay Fever / Allergy							
Back Trouble							
Bursitis							
Cancer							
Constipation							
Depression							
Diabetes							
Digestive Trouble							
Headaches							
Heart Trouble							
Hepatitis							
High Blood Pressure							
Immune Disorder							
Insomnia							
Kidney Trouble							
Liver Trouble							
Migraine							
Neck Pain							
Thyroid Disorder							
Tobacco							
Weight Problem							
Other Emotional Problems: _____							
Other: _____							

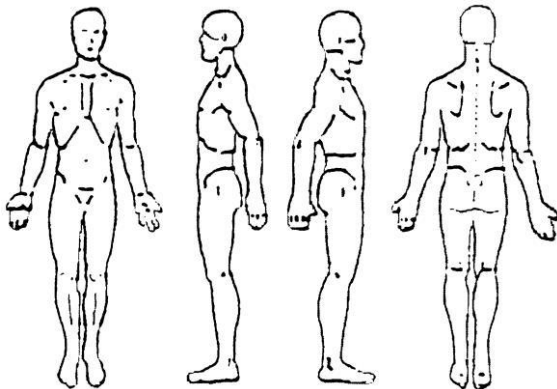
If any of the above family members are deceased, please list their age at death and cause.

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### MUSCULOSKELETAL

- Muscle Cramps – Where?  
  Muscle Pain / Rheumatism – Where?  
  Arthritis – Where?  
 Joint Swelling – Where?  
  Tendonitis – Where?  
  Bursitis – Where?

**Please mark problem areas on diagram:**



#### *Describe Pain and Location*

- |                                |                                       |                                 |
|--------------------------------|---------------------------------------|---------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning      | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Fixed | <input type="checkbox"/> Other: _____ |                                 |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning      | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Fixed | <input type="checkbox"/> Other: _____ |                                 |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning      | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Fixed | <input type="checkbox"/> Other: _____ |                                 |

**Women Only**

Hysterectomy – Ovaries Removed?  Yes  No  
Could You be Pregnant Now?  Yes  No  
Number Of: \_\_\_ Pregnancies \_\_\_ Miscarriages  
                  \_\_\_ Births                   \_\_\_ Abortions

Post-menopausal Bleeding  Yes  No  
When did your last period end? \_\_\_\_\_  
Number of days for monthly cycle? \_\_\_\_\_  
Number of days bleeding lasts? \_\_\_\_\_

Describe Menstrual Flow:  
 Heavy  Moderate  Light  None

Color of Menstrual Flow:  
 Dark  Bright Red  Slightly Reddish

Birth Control:  
 None  IUD  Birth Control Pills  
 Spermicides  Barriers

***Do You Suffer From:***

Cramping (*Mark as appropriate*)  
 Severe  Moderate  
 Mild  Before Period  
 During Period  After Period

Clotting (*Mark as appropriate*)  
 Bright in Color  Dark in Color

Bleeding Between Periods  Infertility  
 Pelvic Inflamm. Disease  Ovarian Cysts  
 Endometriosis  Hot Flashes  
 Mastitis  Breast Cysts  
 Yeast Infection / Vaginitis / Other Discharge

Premenstrual Syndrome (*Mark as appropriate*)  
 Fluid Retention  Cravings  
 Fluctuating Emotions  Irritability  
 Tenderness in Breasts  Depression  
 Fatigue

**Men Only**

Impotence  Weak Erection  
 Discharge from Penis  Prostate Problems  
 Testicular Pain or Lump  Infertility  
 Premature Ejaculation  Low Sex Drive

**Men and Women**  
**Supplements**

Name	Purpose	How Long

**Diet & Lifestyle**

What kinds (circle)	How much per day/week
Sugar: Candy	
Cookies / Baked goods	
Regular Soda / Diet Soda	
Chocolate	
Diary: Milk	
Cheese	
Yogurt	
Ice-cream	
White Flour: Bread	
Pasta	
Coffee	
Alcohol	
Protein 50g per day?	
Eggs	
Dark green/vegetables	
Fruits	
Eat Breakfast?	
Eat fast food / on the run?	

**Additional Notes**

Please tell us about your exercise (regular, minimal, etc.):

Please list what you ate yesterday:

Breakfast \_\_\_\_\_  
Lunch \_\_\_\_\_  
Dinner \_\_\_\_\_  
Snacks \_\_\_\_\_

## **Acupuncture Informed Consent**

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body (small amounts of electrical current may be applied to the needles). The purpose of acupuncture has been explained as the alleviation or cure of symptoms or disorders.

Acupuncture, acupressure, Moxa, cupping therapy, allergy elimination technique, nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis of treatment of any disease or injury. We recommend that you **CONSULT YOUR PHYSICIAN** for any serious conditions and receive at least two medical opinions. It is your right and responsibility for your own body.

I understand that complications may result from acupuncture treatment. Among these possible complications are: areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms. Being hungry, tired, or stressed can infrequently make the body more sensitive to the acupuncture treatment. Please tell your provider if you have any conditions that may inhibit blood clotting, such as hemophilia or coumadin use. Please use caution when walking with bare feet in the treatment room.

I further understand and agree to hold harmless, to indemnify and to protect against court action the individual therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises.

### **Payment Practices**

Wei's Chinese Medical Center gladly accepts health insurance, automobile insurance, and worker's compensation as payment. Insurance coverage depends upon your individual plan. Please call your insurance company to verify your acupuncture benefits. In the event your insurance does not cover acupuncture, discounted charges will be collected at the time of service.

### **Payment Agreement**

I authorize Wei's Chinese Medical Center to release any information required to process this claim to any insurance company or attorney in this case. I also authorize my insurance company or medical provider to release my medical records to Wei's Chinese Medical Center . This information is to be used for the purpose of processing my claims for benefits due. I hereby agree that a photocopy of the document is as valid and effective as the original.

I hereby authorize my insurance benefits to be paid directly to Wei's Chinese Medical Center. I assume full responsibility for and agree to pay all costs, charges, and expenses of every kind and description for services furnished by Wei's Chinese Medical Center . I agree to pay charges and services not covered by any insurance or other third-party payer and/or not paid to Wei's Chinese Medical Center for any reason within a reasonable time (as determined by Wei's Chinese Medical Center). The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator, or third party responsible for payment of the charges.

### **Cancellation Notice**

Please be considerate of your appointment time. We make every effort to respect your time and see you promptly when you are scheduled. Please call if you cannot make your appointment or you are running late. Patients who consistently miss their appointments or fail to cancel 24 hours in advance may be charged for their missed appointments.

I have read and understand the above Informed Consent statement. I agree to the conditions set forth in this statement.

**Patient's Name (Please print):** \_\_\_\_\_

**Signature of patient or legal guardian** \_\_\_\_\_

**Date** \_\_\_\_\_

# Acupuncture Privacy Practices

As your health care provider, we use your health information for evaluation and treatment; as well as to obtain payment for treatment. If you are referred to another health care provider, or at your request, your medical records may be shared with those providers. We may use your health care information without your authorization for the following reasons:

1. Public health safety
2. Auditing purposes
3. Emergencies
4. At the request of your insurance carrier
5. When required by law

In all other circumstances, we will ask your written permission to release your medical information in the form of a "Release of Medical Records" form. If you choose to sign such a form, you have the right to revoke that authorization at any time. If you would like to review our "Notice of Privacy Practices," please request a copy at the front desk. If, at any time, we change our policies regarding your medical information, you will be informed with a new "Privacy Practices" form to sign, as well as a new copy of "Notice of Privacy Practices."

You have the right to view and obtain a copy of your medical record. You also have the right to know to whom we have disclosed your medical records. If you believe the information in your medical record is not correct or missing information, you have the right to request that such information is corrected or added to your medical record.

If you have any questions or concerns about your medical records, please contact Wei's Chinese Medical Center, or you can file a written complaint with the U.S. Department of Health and Human Services. Wei's Chinese Medical Center is required by law to protect your medical information and provide this notice to you, along with your signature acknowledging your receipt of this information.

Wei's Chinese Medical Center reserves the right to change the privacy practices that are described in the "Notice of Privacy Practices." You may obtain a revised "Notice of Privacy Practices" by notifying the office of Wei's Chinese Medical Center and requesting a revised copy. Our office sends thank you cards for referrals, periodic newsletters, and participates in other non-private contact. This may be via email or postal service. Reminders of your appointments may be via email or telephone.

## Consent

I understand that I have a right to read the "Notice of Privacy Practices" prior to signing this form. The "Notice of Privacy Practices" describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations at Wei's Chinese Medical Center. This "Notice of Privacy Practices" also describes my rights, as well as the duties of the practitioner with respect to my protected health information.

I consent to the use or disclosure of my protected health information by Wei's Chinese Medical Center for the purpose of analyzing, diagnosing, or providing treatment; as well as obtaining payment for my health care bills or to conduct health care operations. I understand that analysis and treatment by Wei's Chinese Medical Center may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. is not required to agree to the restrictions that I may request. However, if Wei's Chinese Medical Center agrees to a restriction that I request, the restriction is binding on Wei's Chinese Medical Center. I have the right to revoke this Consent, in writing, at any time, except to the extent that Wei's Chinese Medical Center has taken action in reliance on this Consent.

My "protected health information" means health information, including any demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition that identifies me, or there is a reasonable basis to believe the information may identify me.

**Patient's Name (Please print):** \_\_\_\_\_

\_\_\_\_\_  
**Signature of patient or legal guardian**

\_\_\_\_\_  
**Date**

## Financial Policy for Patient Care Services

Wei's Chinese Medical Center wants to provide the most efficient and affordable health care services, so it is necessary for us to have a financial policy stating our requirements for timely payment of services and products provided by our office. We welcome the opportunity to discuss any aspect of our financial policy.

To help us help you, please:

- 1) Provide us with accurate and updated information on yourself and your insurance company.
- 2) Pay at the time of service for your entire balance.
- 3) Discuss your account balance only with the front office staff. It is important for practitioners to be allowed to provide patient care. If the front office staff cannot help you, do not hesitate to contact the office manager.

### Insurance Patients:

We are happy to file insurance claims as a courtesy to you. It is your responsibility to see that the claims are paid. As stated by your insurance company: **"Verification of benefits is no guarantee of payment."** If you have insurance and we file with your carrier for you, you will be responsible for all charges not paid by the insurance company. The balance due is your responsibility if we have not received payment from your insurance company within 60 days.

Wei's Chinese Medical Center sends claims with procedure codes to the insurance companies. Your insurance company then chooses the "reasonable and customary" amount to apply to your visit. Your insurance plan is a contract between you and your insurance company, therefore any amount applied toward your deductible must be paid in full.

By signing this financial policy:

- 1) You are authorizing Wei's Chinese Medical Center, their providers, and employees to release any necessary information related to this visit and all future visits to your insurance company for the purpose of claim(s) payment. You are giving authorization to submit your claims without obtaining your signature on each and every claim submitted.
- 2) You are authorizing your insurance company and your medical provider to release your medical records to Wei's Chinese Medical Center for the purpose of claim(s) payment.
- 3) You are authorizing your insurance company to pay any medical benefits and all future claims for services provided by our office directly to Wei's Chinese Medical Center.
- 4) You are giving Wei's Chinese Medical Center the right to speak with your insurance company, any third party insurance company, and your attorney regarding your claims and bills.
- 5) You agree that a photocopy of any document is as valid and effective as the original.

## Healthy People are Happy People

\_\_\_\_\_  
Patient's Name (please print)

\_\_\_\_\_  
Responsible Party or Authorized Person Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Wei's Chinese Medical Center Signature

\_\_\_\_\_  
Date



