TSUI ACUPUNCTURE
PHONE:510.730.0608
EMAIL: TSUIACUPUNCTURE@GMAIL.COM

WELCOME!
This intake form is extremely detailed. The more I know about what's going on for you, the better we can develop a treatment plan. Please provide as much information as you can, even if it seems unrelated to your reason for coming in.

CONFIDENTIALITY
Your patient records and information will be kept strictly confidential and will only be shared when necessary to provide care, or under your written authorization, or when required by law.

PATIENT INFORMATION (Please Print and complete in full) ____New Patient ____Established Patient

Legal Last Name: _____ Legal First Name:_____

Preferred Name: _____ Today's Date:_____

Cell #: _____Home #: _____Work #_____

Address:_____

City _____State: _____ZIP_____

Email: _____Fax #:_____

Patient Status: ___Married ___Single ___Divorced ___Widowed ___Other_____

Birth Date:_____ Age: _____SSN (last 4 digits) : _____

Gender: _____Male _____Female ____MTF ____ FTM

Referred to our Clinic By: _____

EMERGENCY

Emergency Contact: _____ Relationship: _____

Cell #: _____Home #: _____Work #_____

INSURANCE INFORMATION (Only some insurance companies will cover acupuncture)

Primary Insurance: _____ Telephone #: _____

Policy Holders Name (if different): _____ Relationship: _____

Policy # / ID #: _____Group #: _____

Insurance Billing Address: _____

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1. MAIN CONCERNS

Health Goal / Chief complaints	Severity (1-10)	How Long?
1.		
2.		
3.		

What % of time do you have pain in a 24 hour period?
Complaint 1: 10 20 30 40 50 60 70 80 90 100%
Complaint 2: 10 20 30 40 50 60 70 80 90 100%
Complaint 3: 10 20 30 40 50 60 70 80 90 100%

Since injury, Condition has : ڤ Improved ڤ Deteriorated ڤ No Change ڤ 1st Visit

What sort of measures have you taken to improve your condition, and did it help?

Please describe the type of pain (what does it feel like?)
ڤ Sharp ڤ Burning ڤ Dull ڤ Aching ڤShooting ڤ Tingling ڤNumb ڤ Stiffness ڤ Cramps
ڤ Other ڤ Swelling

What relieves the pain?
ڤ Heat ڤ Cold ڤ Rest ڤ Exercise ڤ Acupuncture ڤ Massage ڤ Chiropractic ڤ Physiotherapy

List Activities or movements that are painful to perform:
ڤ Sitting ڤ Bending ڤ Standing ڤ Lying down ڤ Walking ڤ Lifting ڤ other_____

Does your pain interfere with your
ڤ Sleeping ڤ Dressing ڤ Tying Shoes, ڤ Work performance ڤ Bathing ڤ Toileting ڤ Preparing food
ڤ Eating ڤ Taking medicine ڤ Walking ڤ Exercising ڤ Other _____

2. GENERAL HEALTH

Rate your energy level: Not much energy 1 2 3 4 5 6 7 8 9 10 lots of energy

Rate your stress level: Not so stressed 1 2 3 4 5 6 7 8 9 10 Super stressed

please indicate usage & frequency of the following

	Age Started	Age Quit	Amount per day
Coffee			
Tobacco			
Alcohol			
Marijuana			
Other Substances (specify)			

Patient Name: _____ Date: _____

Do you excercise? What & how much?

Do you enjoy your work? How many hours per week?

What do you *love* to do for fun?

3. HEALTH HISTORY

Please provide details of any hospitalizations, surgeries including reason and dates:

Any serious illness, including single occurrence, recurring or chronic?

Please list any current medications, supplements and herbal remedies:

List all allergies including Medications, Seasonal , Environmental & Food:

General			
☐ anemia ☐ anticoagulant medications ☐ arthritis	☐ blood disorder ☐ breast lumps ☐ cancer /tumor ☐ convulsion seizure	☐ diabetes ☐ drug abuse ☐ epilepsy ☐ haemophiliac	☐ pacemaker ☐ heart disease ☐ Lung disease ☐ scheduled surgeries:
Body			
☐ prefer warm drinks ☐ prefer cold drinks ☐ wake with a bitter taste in my mouth	☐ body runs hot ☐ body runs cold ☐ body runs neutral	☐ fatigue ☐ fevers ☐ strong thirst	☐ chills ☐ localized weakness ☐ poor coordination ☐ poor memory
Sleep			
☐ sleep is restful ☐ sleep is light ☐ hard to fall asleep	☐ wake easily / early ☐ dream disturbed sleep	☐ nightmares ☐ heavy sleep	☐ night sweats ☐ hours of sleep:

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Head & Neck			
☐ headache ☐ migraine	☐ dizziness ☐ fainting	☐ neck stiffness ☐ enlarged lymphs	☐ concussions
Eyes			
☐ blurred vision ☐ spots / floaters	☐ eye pain ☐ dry eyes	☐ poor night vision ☐ red/burning/itchy eyes	☐ Visual changes
Nose, Throat, Mouth			
☐ hay fever / allergies ☐ nose bleeds ☐ sinus infections	☐ sore throat ☐ swollen glands ☐ bleeding gums	☐ hard to swallow ☐ bitter taste	☐ mouth sores ☐ dry mouth
Skin, Hair, Nails			
☐ hives ☐ rashes ☐ eczema	☐ psoriasis ☐ acne ☐ itchiness	☐ dryness ☐ mole / tumor / lump change	☐ bruise easily ☐ fine hair / falling out ☐ nails break easily
Respiratory			
☐ wheezing / asthma ☐ difficulty breathing ☐ chronic cough	☐ coughing phlegm ☐ coughing blood	☐ frequent colds ☐ COPD	☐ Bronchitis ☐ Pneumonia
Cardiovascular			
☐ heart palpitations ☐ rapid heartbeat ☐ irregular heartbeat	☐ high blood pressure ☐ low blood pressure ☐ chest pain / tightness	☐ poor circulation ☐ fainting	☐ phlebitis ☐ swollen hands / feet
Gastro-intestinal			
☐ nausea ☐ vomiting ☐ acid reflux / heartburn ☐ gas ☐ bloating ☐ abdominal pain / cramping	☐ frequent hiccups ☐ bad breath ☐ poor appetite ☐ ravenous appetite ☐ hunger with no desire to eat	☐ loose or soft stools ☐ constipation ☐ alternating loose / constipation ☐ laxative use ☐ black stools	☐ blood in stools ☐ mucous in stools ☐ burning anus ☐ itch / pain in the anus ☐ rectal pain
Genito-Urinary			
☐ pain/itchy genitalia ☐ genital discharge ☐ frequent urinary tract infection	☐ painful urination ☐ frequent urination ☐ urgent urination ☐ excessive urination	☐ scanty urination ☐ blood in the urine ☐ wake up to urinate	☐ kidney stones ☐ increased libido ☐ decreased libido
Male System			
☐ prostatitis	☐ lumps in testicles	☐ impotence	☐ weak urinary stream

Patient Name: _____ Date: _____

Psychological			
☐ relaxed & calm ☐ sad ☐ fearful	☐ depressed ☐ angry / frustrated ☐ irritated easily	☐ anxious ☐ stressed ☐ overthink / worry	☐ forgetful ☐ manic ☐ impatient
Infectious Screening (+) results			
☐ HIV ☐ TB	☐ Hepatitus ☐ Gonorrhea	☐ Chlamydia ☐ Syphillis	☐ Genital Warts ☐ Herpes: oral/genital
Food Preferences			
☐ Vegetarian ☐ Vegan	☐ Pescatarian	☐ Omnivore	☐ Food intolerances:

4. EXPECTIATIONS OF CARE

In order to provide you with the care that you need, it is important to know more about where you are at in your desire to be well, and how you would like to work together:

For your first visit, what are your expectations of the clinic? And what are your expectations of me for today and ongoing?

Please describe your lifestyle habits that will support & hinder your health:

Please provide any additional comments that you feel is relevant:

5. FEMALE BODY SYSTEMS

Pregnant? ☐ Unusre ☐ Yes ☐ No Ages of Children_____

____Total Pregnancies ___ Ectopic ___Miscarriages ___Induced Abortions ____Cesareans

Form of birth control? ☐ None ☐ Pill ☐ Other (Condom, Vasectomy, _____)

First day of last menstruation_____ # Days between Periods_____ # Bleeding Days _____

Menstrual Blood Color:_____Age started menstrual Cycle_____ Age Stopped_____

History of or Current infections:_____
Discharge: Yellow / White / Clear / Odor/ Itch

Do you have Menopausal Syndrome? ___ Hot flashes ___other _____

Other information:
_____

Patient Name: _____ Date: _____

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FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

Fees: Our fees are determined by the complexity of each case and different services used.

Regarding insurance: We will verify coverage prior to treatment and we will file all claims as a courtesy to you. If for any reason we are not able to verify coverage prior to your treatment, you will be charged for the treatment until verification is obtained. We cannot bill your insurance unless you bring us all necessary insurance information. We are not a party to that contract. By signing this document, you are assigning to this office the benefits to which you are eligible to receive for care rendered in this office. Additionally, in signing this document you authorize the release of any information to any insurance company, adjuster or attorney that will assist in the payment of a claim. We request a credit card on file if the insurance company should not pay claims or any balances owed should there be any difference in the amount owed. _____ initial

Usual and Customary Rates UCR: Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. Please be aware that some and at times perhaps all of the services may be non-covered services and not considered reasonable and necessary by medical insurance. All payments are due at the time of service.

Missed Appointments: Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointment at the rate of a normal office visit if you are a repeat offender of this rule. Your treatments will be more effective if you follow your physician's guidelines and stick to your treatment schedule. Please help us to serve you better by keeping your scheduled appointments. Please let us know if you have any questions or concerns. I have read the financial policy and I agree to this financial policy. _____ initial

Insurance Responsibility, Assignment and Release, Authorization to Bill insurance:
There are two billing options available for you. Please select the one you prefer us to use for your visits. If at any time if you choose to change your billing option, you are required to let us know immediately and sign a new Office Financial Policy and Authorization to Bill Insurance Form.

_____ **Private Pa**y
Private Pay patients are patients that do not bill insurance. This discounted cash rate is only applied to the published rate if you pay at the time of service.

_____**Insurance Billing (Medical Insurance)**
I understand that I must pay all co-payments and/or co-insurances not covered by my insurance company at the time of check in for today's visit, and every visit hereafter. Tsui Acupuncture will submit my claim for me to my insurance company. Although Tsui Acupunture verifies my insurance; **I understand that this verification is not a guarantee of payment.** I understand that any and all charges incurred at this office including co-payment, co-insurance, percentage due and/or deductibles or any other fees or services not covered by my insurance company are **my responsibility. I understand that if these patient portions due are not paid at the time of service I will be subject to a $10.00 billing fee per month – no exceptions until the outstanding amounts are paid.** I further understand that any unpaid balance over **90 days**, can and will be sent to collections for recovery unless prior arrangements have been made.

I authorize my insurance benefits to be paid directly to Tsui Acupuncture. I also authorize the provider to release any information and medical records required by my insurance company. I understand that I may revoke this consent by written request, at any time. No other records shall be released without my signed consent.

_____ _____
Signature of Responsible Party or (Person Authorized to Consent) Date

Patient Name: _____ Date: _____

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INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while working or associated with, or serving as a back-up for the acupuncturist named below, including those working at this or any other office, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, exercise therapy Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue.

I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____
Signature of Responsible Party or (Person Authorized to Consent) Date

Patient Name: _____ Date: _____

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HEALTH INFORMATION PRIVACY POLICY

Dear Valued Patient,

This notice describes the office's policy for how medical information about you may be used and disclosed and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information in the following cases:

- Payment: In order to secure payment we may disclose health care information to your insurance company or with Worker's Compensation (and your employer as well in this instance)
- Treatment: Your health care information may be disclosed to other healthcare professionals within the practice or other medical practitioners that you authorize
- Emergencies: In the event of an emergency, we may need to notify a family member or other person responsible for your care that you have been in an emergency situation.
- Public Health: As required by law, we may disclose your health information to public health authorities for the purpose of preventing or controlling disease, reporting child or elder abuse or neglect, reporting domestic violence or reporting disease or infectious exposure, for example
- Judicial and Administrative Proceedings or Law Enforcement: For example in the case of complying with a court order or subpoena.
- Other Communication: For example, we may call your home to remind you of an appointment. No protected health information will be provided on this call except for the date and time of your scheduled appointment.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

In administering your health care, we gather and maintain information that may include:

- Non-public personal information
- Information about your financial transactions with us (billing transactions)
- Medical history, treatment notes, medical test results, and any letters, faxes, emails or telephone conversations to or from this office, to or from other health care practitioners, from health care providers, insurance companies, workman's comp and your employer, and other third part administrators (e.g. requests for medical records, claim payment information).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 510.730.0608

Sincerely,

Angela Tsui, Lac.

By signing this document, I acknowledge that I have reviewed or received a copy of Tsui Acupuncture's Health Information Privacy Policy

_____ _____

Signature of Responsible Party or (Person Authorized to Consent) Date

please write your email if you would like electronic copy of this Health Information Privacy Policy.

Email to: _____

Patient Name: _____ Date: _____