



TIAN SHI ACUPUNCTURE

Caring for the Whole You

Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential.

PATIENT INFORMATION

Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Birth Date _____ Age _____ M _____ F _____

Marital Status _____ Occupation _____

Your Physician _____

Physician's Phone _____

How did you hear about our office? _____

Have you ever had acupuncture? _____

CONTACT INFORMATION

Home Phone _____

Work Phone _____

Cell Phone _____

E-mail _____

Emergency Contact: _____

Name _____

Relationship _____

Home Phone _____

Work Phone _____

Cell Phone _____

MEDICAL HISTORY

Reason for visit today _____

How long have you had this condition? _____ Is it getting worse? _____

What seemed to be the initial cause? _____

Is your condition related to an auto accident or employment? _____

What seems to make it better? _____

What seems to make it worse? _____

What other treatments have you tried for this condition? _____

List medications/supplements taken in the last two months _____

FAMILY HISTORY (please check any of the following that have occurred in your blood relatives)

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Other _____
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures	

PAST MEDICAL HISTORY (please check any conditions you have or have had in the past)

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Measles	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Allergies	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mumps	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Goiter	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid Disorders
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gout	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Birth Trauma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Polio	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Other (list below)
<input type="checkbox"/> Surgery (list below)	<input type="checkbox"/> Major Trauma (car, fall, etc. [list below])		

Details: _____

HEALTH HISTORY *(please check any symptoms you currently have or have had in the past year)*

GENERAL SYMPTOMS

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Like cold drinks | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Chills | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Like hot drinks | <input type="checkbox"/> Lack of strength | <input type="checkbox"/> Fever | <input type="checkbox"/> Vertigo/dizziness |
| <input type="checkbox"/> Recent weight loss/gain | <input type="checkbox"/> Bodily heaviness | <input type="checkbox"/> Aversion to cold | <input type="checkbox"/> Muscle cramps |
| <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Aversion to heat | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heavy sleep | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Night sweats | |
| <input type="checkbox"/> Dream-disturbed sleep | <input type="checkbox"/> Peculiar taste (describe below) | | |

Details: _____

HEAD, EYES, EARS, NOSE, THROAT

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Nasal discharge |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Excessive phlegm
(Color _____) | <input type="checkbox"/> Nasal obstruction |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> TMJ | <input type="checkbox"/> Lumps in throat | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Gum problems | <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> Ear discharge |
| <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Excessive saliva | | <input type="checkbox"/> Other _____ |

Details: _____

SKIN/HAIR

- | | | | |
|--|------------------------------------|--|--|
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Brittle hair/nails | <input type="checkbox"/> Dark circles under eyes |
| <input type="checkbox"/> Hematomas | <input type="checkbox"/> Eczema | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Bags under eyes |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Acne | <input type="checkbox"/> Premature gray hair | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Oily skin | <input type="checkbox"/> Hair loss | |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Dry scalp | |

Details: _____

RESPIRATORY

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Sensitivity to heat |
| <input type="checkbox"/> Cough (<input type="checkbox"/> Wet <input type="checkbox"/> Dry) | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Sensitivity to cold |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Sensitivity to humidity | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Snoring | <input type="checkbox"/> Sensitivity to dryness | |
| <input type="checkbox"/> Phlegm/sputum | <input type="checkbox"/> Tightness in chest | <input type="checkbox"/> Sensitivity to wind | |

Details: _____

CARDIOVASCULAR

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Swelling of ankles | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Edema | |

Details: _____

GASTROINTESTINAL

- | | | | |
|-----------------------------------|---|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Hiccup | <input type="checkbox"/> Intestinal pain | <input type="checkbox"/> Bloody stools |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Diarrhea/loose stools | <input type="checkbox"/> Mucous in stools |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Constipation | <input type="checkbox"/> Hemorrhoid |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Stomachache | <input type="checkbox"/> Black stools | <input type="checkbox"/> Other _____ |

Details: _____

MUSCULOSKELETAL

Pain, numbness, and/or weakness in:

- Arms
- Elbows
- Wrists
- Hands
- Shoulders
- Legs
- Hips
- Knees
- Ankles
- Feet
- Neck
- Upper back
- Middle back
- Lower back
- Joints
- Other _____

Details: _____

NEUROPSYCHOLOGICAL

- Paralysis
- Tremor
- Seizures
- Poor memory
- Difficulty focusing/concentrating
- Depression
- Anxiety
- Irritability
- Mood swings
- Easily stressed
- Feel angry
- Feel sad
- Forgetful
- Mind not clear
- Fear
- Nervousness
- Suicidal thoughts
- Other _____

Details: _____

GENITO-URINARY

- Bed wetting
- Inability to control urine
- Other _____
- Blood/pus in urine
- Kidney infection/stones
- Decreased libido
- UTI
- Frequent urination
- Wake to urinate

Details: _____

MEN ONLY

- Diminished libido
- Prostate problems
- Erection difficulties
- STD
- Genital pain
- Other _____
- Penis discharge

Details: _____

WOMEN ONLY

- Currently pregnant
- May be pregnant
- Pregnancy(s)_____
- Miscarriage(s)_____
- Contraceptives
- Abnormal PAP
- Menopausal symptoms
- Diminished libido
- Vaginal infections
- Yeast infections
- STD
- Other _____
- Vaginal prolapse
- Uterine prolapse
- Endometriosis

Menstruation:

- Bleeding: Heavy Normal Light
- Onset _____ Cycle length _____ Days of flow _____ Color _____
- Painful periods
 - Post menstrual pains
 - Clots in menses
 - PMS
 - Bleed between periods
 - Mood swings
 - Irregular periods

Details: _____

DIET & LIFESTYLE (List average daily menu)

Morning	Snack	Noon	Snack	Evening	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

- Alcohol
- Caffeine
- Drugs
- Other _____
- Tobacco
- Artificial sweetener
- Sugar
- Good appetite
- Poor appetite
- Stress
- Occupational hazards
- Exercise excessively
- Exercise regularly

Details: _____

Signature _____ Date _____

INITIAL PATIENT CONDITION ASSESSMENT

Name _____

Date _____

Please specify major complaints, conditions, and/or symptoms:

1. _____

2. _____

3. _____

Symptom/Condition Rating

Please complete rating scales below for the categories that are affected by your condition(s).

RATING SCALE IS SUBJECTIVE: 0 = No Problem 10 = Worst

Pain/numbness	0 1 2 3 4 5 6 7 8 9 10	Reproductive/Sexual	0 1 2 3 4 5 6 7 8 9 10
Headache	0 1 2 3 4 5 6 7 8 9 10	Exercise/Recreational	0 1 2 3 4 5 6 7 8 9 10
Fatigue	0 1 2 3 4 5 6 7 8 9 10	Standing/Walking	0 1 2 3 4 5 6 7 8 9 10
Sleep	0 1 2 3 4 5 6 7 8 9 10	Relationships	0 1 2 3 4 5 6 7 8 9 10
Irritability	0 1 2 3 4 5 6 7 8 9 10	Job Productivity	0 1 2 3 4 5 6 7 8 9 10
Digestion	0 1 2 3 4 5 6 7 8 9 10	Anxiety	0 1 2 3 4 5 6 7 8 9 10
Urinary	0 1 2 3 4 5 6 7 8 9 10	Depression	0 1 2 3 4 5 6 7 8 9 10
Bowel	0 1 2 3 4 5 6 7 8 9 10	Overall Outlook	0 1 2 3 4 5 6 7 8 9 10

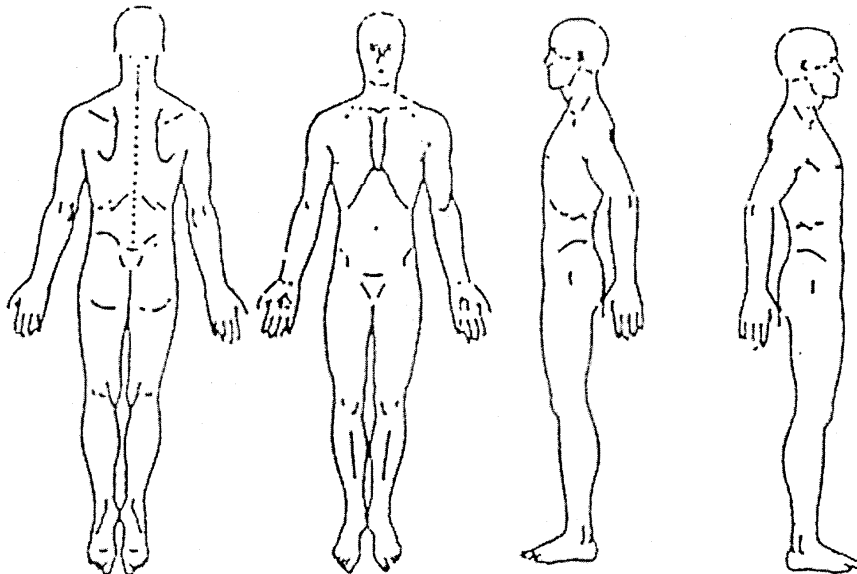
Frequency of symptom(s) and/or pain (day refers to a 24-hour period)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Occasional
<25% of the day | <input type="checkbox"/> Intermittent
<50% of the day | <input type="checkbox"/> Frequent
<75% of the day | <input type="checkbox"/> Constant
Up to 100% of the day |
|--|--|--|--|

Please indicate the number of days per week you experience these symptoms and/or pain _____

Pain Assessment Diagram

If pain is a component of your condition, please mark each painful area on the body images with a numbered 1-10 to indicate the severity of your pain (if applicable).



Please provide any further details or clarification on any of the above subjects/categories as deemed necessary:



Consent to Medical Treatment

I voluntarily consent to receive Acupuncture and/or Chinese Herbal Medicine treatment administered by Batbayar Damdin, Dipl. Ac., L.Ac. I understand his training is in Acupuncture and Oriental Medicine and that he is not, nor claims to be, a medical doctor. I understand that the practice of Traditional Chinese medicine is not an exact science and diagnosis and treatment may involve risk of injury. I acknowledge that no guarantee has been made to me as to the results of any examination or treatment by Batbayar Damdin, Dipl.Ac., L.Ac.

Initials _____

Financial Policy

The following is a statement of Tian Shi Acupuncture’s Financial Policy. All patients must complete the Patient Intake and Office Policy forms before receiving treatment from Batbayar Damdin, Dipl. Ac., L.Ac. Full payment is due at the time of service for all office visits and procedures. No discounts for services or products will be allowed unless written and agreed upon by Batbayar Damdin. The terms of any applicable prepayment discounts, treatment packages, or third-party financing plans are available for review at our office. We accept cash, checks, and credit or debit cards. This office is not a participating provider with any insurance carrier. However, if your insurance carrier does cover your services, you may elect to forward your receipts of payment for reimbursement.

This office requests 24-hour notification of any change to or cancellation of an appointment. If less than 24-hour notice is provided, you will be charged \$35 for a cancelled appointment. If no notice of appointment cancellation is provided, it is our policy to charge the missed visit at the normal office visit rate of \$75. If the appointment was purchased in a package, the missed appointment charge will be deducted from the remaining appointments in the package. This office recognizes that emergencies and extenuating circumstances arise and those will be considered on an individual basis.

Accounts are considered delinquent after 60 days. Interest will be charged accordingly to all past- due accounts. Any collection charges that are incurred on balances that are turned over to a collection agency or legal representative are the responsibility of the patient.

Initials _____

I have read and understand each of the sections contained above. I understand that by signing this document, I am agreeing to and providing the authorization/consent contained in each of the above sections where my initials or those of my representative are located. I have had the opportunity to ask questions regarding each of these sections and all such questions have been answered to my satisfaction.

Signature of Patient or Representative

Print Name

Date

Relationship to Patient if Representative



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
AND CONSENT TO OBTAIN, USE, AND DISCLOSE HEALTH INFORMATION**

Notice of Privacy Practices

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment. Prior to signing this acknowledgement and consent, I have had the opportunity to review the Notice of Privacy Practices in this organization’s office or at www.tianshiacupuncture.com.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

Request for restrictions

This organization will release information relating to my office appointments, directions for treatment or herbal supplements via telephone calls, answering machine messages, facsimile, or electronic mail. This organization may also communicate general information to you about the practice of acupuncture via newsletter using the name, address, and e-mail information you provided.

Please specify below any request to restrict the use, dissemination, or method of communication of your medical information as provided in the Notice of Privacy Practices, including notification to your primary care provider that you are receiving treatment at Tian Shi Acupuncture.

I hereby acknowledge that I have received and understand the Notice of Privacy Practices, consent to the use and disclosure of information as described therein, and release Batbayar Damdin, Dipl. Ac., L. Ac. and his employees from any legal responsibility or liability in connection with the disclosure of the information.

Signature of Patient or Representative

Print Name

Date