



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 _____



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PATIENT INFORMATION

Name _____ Date _____
OB/GYN Name _____ OB/GYN Phone # _____

PREMENSTRUAL SYMPTOMS

Check if you have any of the following symptoms:

- Acne
- Fatigue
- Irritable, depressed
- Bloating abdomen
- Sore, tender breasts
- Mood swings

<input type="checkbox"/> Abdominal pain (circle one)	Before period	During period	After period
<input type="checkbox"/> Low back pain (circle one)	Before period	During period	After period
<input type="checkbox"/> Loose stools (circle one)	Before period	During period	After period
<input type="checkbox"/> Headaches (circle one)	Before period	During period	After period

Other _____

MENSTRUAL CYCLE

Age at which menses began _____
 Have your cycles changed since they began? Yes No How? _____
 Date of last menstrual period _____ How many days between cycles? _____
 Do you bleed or spot between periods? Yes No
 Are your menstrual cycles spaced irregularly? Yes No Please explain _____
 How long does your period last? _____
 Are your periods painful? Yes No How many days does the pain last? _____
 How heavy is the bleeding? Light Medium Heavy
 What color is the blood? Light red Red Dark red Purple Brown Black
 Is there clotting? Yes No Clot size: _____ Is there any mucus? Yes No
 On what day of your cycle do you ovulate? _____
 What method do you use to determine ovulation? _____
 Do your breasts get tender at/during ovulations? Yes No
 Do you have pain or cramping during ovulation? Yes No Where? _____
 Do you notice an increase in discharge within the first two weeks after your period? Yes No
 If you answered "yes" above, please fill in the next two questions:
 First week discharge is: Light Medium Heavy Texture: Clear/stretchy Thick/cloudy
 Second week discharge is: Light Medium Heavy Texture: Clear/stretchy Thick/cloudy

GYNECOLOGY HISTORY

Have you ever been diagnosed with any of the following:

- Endometriosis
- Endometritis
- Amenorrhea
- Anovulation
- Venereal disease
- Chlamydia
- Genital herpes
- HPV (human papilloma virus)
- Inherited genetic abnormalities in the parents
- Uterine fibroids or polyps
- Pelvic inflammatory disease
- POF (premature ovarian failure)
- Pelvic inflammatory disease
- PCOS (polycystic ovary syndrome)
- Hypothalamic anovulation
- Hyperprolactinaemia
- Resistant ovary syndrome
- Tumors in the ovaries
- Tumors in the adrenal glands
- Tumors in the pituitary glands
- Fallopian tube blockage
- Uterine and cervical abnormality
- Candidiasis
- Other _____

If yes to any of the above, when were you treated? _____
 How were you treated? _____

Have you ever had any of the following?
 Yeast infections regularly Chronic vaginal discharge Painful intercourse

Please fill in the following if applicable:

	Number	Year		Number	Year
Pregnancy(ies)	_____	_____	Miscarriages	_____	_____
Children	_____	_____	D&Cs	_____	_____
Abortions	_____	_____	Tubal Pregnancy(ies)	_____	_____

Have you ever taken oral contraceptives? Yes No When? _____ How long? _____
 Have you ever had an IUD? Yes No When? _____ How long? _____
 Have you ever had a cervical biopsy, operation, cauterization, or conization? Yes No
 Have you ever had an abnormal Pap smear? Yes No
 Date of last Pap smear: _____
 Other gynecological procedures: _____
 Gynecological surgeries: _____

FERTILITY TREATMENT HISTORY

How long have you been trying to conceive? _____
 Do you have a diagnosis related to infertility? _____
 Has there been a sperm analysis? Yes No What were the results? _____
 Is there or was there any indication of male factor infertility? Yes No What is it? _____
 Have you ever conceived naturally in the past? Yes No How many times? _____
 Have you had fertility treatments? Yes No
 If yes, when and where? _____

 What types? _____
 What were the results? _____
 Have you taken medication to help you ovulate? Yes No When? _____ How long? _____
 What were the results? _____
 Have you had a fallopian tube evaluation? Yes No What were the results? _____
 Have you had other functional tests? Yes No What were the results? _____
 What hormonal laboratory tests were performed? _____
 What were the results? _____
 Have you had a mid-cycle vaginal ultrasound? Yes No What were the results? _____
 Have you had a post-coital test? Yes No What were the results? _____
 Diagnosed with hostile cervical mucus? Yes No

Please list all medications you are currently taking for infertility:

Medication	Reason	Duration	Medication	Reason	Duration
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

LIFESTYLE

How is your sexual energy? Low Medium High
 Do you douche regularly? Yes No
 Do you use vaginal lubricants? Yes No
 Are you more than 20% over your ideal body weight? Yes No
 Are you more than 20% below your ideal body weight? Yes No
 Do you have a stressful occupation? Yes No
 Do you exercise regularly? Yes No What kind? _____
 Do you have excessive facial hair? Yes No
 Do you have excessively oily skin? Yes No
 Have you noticed discharge from your nipples? Yes No
 Have you experienced an excessive loss of hair? Yes No
 Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? Yes No
 Have you been exposed to any known environmental toxins or hormones? Yes No
 Have you or your partner ever had X-rays? Yes No
 Are you presently taking steroids? Yes No

Please check any symptoms you have or have had since your first period.

- | | | |
|--|---|--|
| <input type="checkbox"/> Shadow around or under eyes | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> No fertile mucus |
| <input type="checkbox"/> Low energy | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Irregular ovulation |
| <input type="checkbox"/> Difficulty with urination | <input type="checkbox"/> Developmental disorders in reproductive organs | <input type="checkbox"/> Late puberty |

OFFICE USE ONLY (DX: KIDNEY JING DEFICIENCY)
 BBT: No pattern or not recorded
 Follicular phase: _____
 Luteal phase: _____
 Pulse: weak and thready
 Rt. Cun: _____ Guan: _____ Chi: _____ Tongue: pale
 Lt. Cun: _____ Guan: _____ Chi: _____ Body: _____
 Coat: _____

- | | | |
|--|--|--|
| <input type="checkbox"/> Prematurely gray hair | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Hair loss | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Dry hair | <input type="checkbox"/> Low back pain or soreness | <input type="checkbox"/> Heavy, bright red periods |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Menstrual bleeding is light or scanty |
| <input type="checkbox"/> Dry throat | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Vaginal dryness |
| <input type="checkbox"/> Thirsty | <input type="checkbox"/> Heat sensation in chest, palms, and soles | <input type="checkbox"/> Cervical mucus scanty or missing |

OFFICE USE ONLY (DX: KIDNEY YIN DEFICIENCY)
 BBT :
 Follicular phase: unsteady, longer than 13 or 14 days or average temperature around 98° F, short follicular phase if Yin-deficient heat
 Luteal phase: poor temperature rise
 Pulse: weak/deep lvl., floating/superficial lvl., rapid/Yin-def. heat
 Rt. Cun: _____ Guan: _____ Chi: _____ Tongue: dry, small, red, little coat
 Lt. Cun: _____ Guan: _____ Chi: _____ Body: _____
 Coat: _____

- | | | |
|--|---|---|
| <input type="checkbox"/> Low back pain or soreness | <input type="checkbox"/> Often fearful | <input type="checkbox"/> Profuse vaginal discharge |
| <input type="checkbox"/> Leg pain /worsens in cold | <input type="checkbox"/> Wake up to urinate | <input type="checkbox"/> Period cramps alleviated with heat |
| <input type="checkbox"/> Knee pain/worsens in cold | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Premenstrual low back pain |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Get cold easily | <input type="checkbox"/> Menstrual blood that is dull in color |
| <input type="checkbox"/> Low libido | <input type="checkbox"/> Cold feet (especially at night) | <input type="checkbox"/> Clots during period |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Early morning loose, urgent stools | <input type="checkbox"/> Diarrhea just before or at the beginning of period |

OFFICE USE ONLY (DX: KIDNEY YANG DEFICIENCY)
 BBT:
 Follicular phase: 96.8° F. or less
 Luteal phase: not high or doesn't stay raised
 Pulse: slow, deep
 Rt. Cun: _____ Guan: _____ Chi: _____ Tongue: pale and swollen
 Lt. Cun: _____ Guan: _____ Chi: _____ Body: _____
 Coat: _____

- | | | |
|---|--|---|
| <input type="checkbox"/> Foul-smelling vaginal discharge | <input type="checkbox"/> Vaginal itching | <input type="checkbox"/> Rectal itching |
| <input type="checkbox"/> Yellow or greenish vaginal discharge | | |

OFFICE USE ONLY (DX: DAMP HEAT)
 BBT :
 Follicular phase: _____
 Luteal phase: _____
 Pulse: _____ Tongue: _____
 Rt. Cun: _____ Guan: _____ Chi: _____ Body: _____
 Lt. Cun: _____ Guan: _____ Chi: _____ Coat: _____

- Hysteria
- Anxiety
- Agitation

- Fidgety
- Insomnia
- Nightmares

- Heart palpitation
- Irregular ovulation
- No ovulation

OFFICE USE ONLY (DX: HEART QI STAGNATION)
 BBT:
 Follicular phase: unsteady graph

Luteal phase: high if there is Heart fire

Pulse: choppy or thready
 Rt. Cun: _____ Guan: _____ Chi: _____ Tongue: red tip
 Lt. Cun: _____ Guan: _____ Chi: _____ Body: _____
 Coat: _____

- Easily depressed
- Uncontrollable anger
- Headaches
- Difficulty falling asleep
- Heartburn
- Bitter taste
- Nipple discharge
- Feel bloated around ovulation
- Irritable around ovulation
- Breasts sensitive at ovulation
- Premenstrual bloating
- Premenstrual breast/nipple soreness
- Premenstrual irritability
- Painful period
- Menstrual cramps
- Clots during period
- Menstrual blood is thick or dark
- Menstrual blood is purple

OFFICE USE ONLY (DX: LIVER QI STAGNATION)
 BBT:
 Follicular phase: instability

Luteal phase:

Pulse: wiry
 Rt. Cun: _____ Guan: _____ Chi: _____ Tongue: red (fire) or purple (blood stagnation)
 Lt. Cun: _____ Guan: _____ Chi: _____ Body: _____
 Coat: _____

- Painful, unmovable breast lumps
- Lower abdominal tenderness/pain
- Lumps in lower abdomen
- Vascular abnormality
- Varicose or spider veins
- Numbness in hands and feet
- Blood clotting disorder
- Pituitary tumors
- Endometriosis
- Uterine fibroids or polyps
- Fallopian tube blockages
- Ovarian cysts and tumors
- Brown or black menstrual flow
- Clots during period
- Mid-cycle pain around ovaries
- Piercing /stabbing menstrual cramps

OFFICE USE ONLY (DX: BLOOD STASIS)
 BBT:
 Follicular phase: high initially

Luteal phase:

Pulse: choppy or tight
 Rt. Cun: _____ Guan: _____ Chi: _____ Tongue: purple or some purple areas
 Lt. Cun: _____ Guan: _____ Chi: _____ Body: _____
 Coat: _____

- Crave sweets
- Poor appetite
- Energy becomes lower after a meal
- Feel bloated after eating
- Hypothyroidism
- Anemia
- Prone to feeling heavy or sluggish
- Lack of strength in arms and legs
- Lack of strength in breathing
- Loose stools
- Abdominal pain
- Hemorrhoids or polyps
- Allergies
- Bruise easily
- Poor circulation
- Varicose veins
- Excessive worry
- Sweat easily
- Low blood pressure
- Feel dizzy or light-headed
- Uterine prolapse
- Tired around ovulation
- Spotting before period
- Tired around menstruation
- Menstrual cramps
- Thin or watery periods
- Profuse or pinkish periods

OFFICE USE ONLY (DX: SPLEEN QI DEFICIENCY)
 BBT:
 Follicular phase:

Luteal phase:

Pulse: weak or slippery
 Rt. Cun: _____ Guan: _____ Chi: _____ Tongue: swollen with teeth marks
 Lt. Cun: _____ Guan: _____ Chi: _____ Body: _____
 Coat: _____

- | | | |
|---|--|--|
| <input type="checkbox"/> Dizzy | <input type="checkbox"/> Like rich, sweet food | <input type="checkbox"/> Endometrial congestion |
| <input type="checkbox"/> Oppressed feeling in the chest | <input type="checkbox"/> Foul-smelling stools | <input type="checkbox"/> Prone to yeast infections |
| <input type="checkbox"/> Heart palpitation | <input type="checkbox"/> Pituitary tumors | <input type="checkbox"/> Prone to vaginal itching |
| <input type="checkbox"/> Feel tired and sluggish after a meal | <input type="checkbox"/> Blocked fallopian tubes | <input type="checkbox"/> Excessive vaginal discharge |
| <input type="checkbox"/> Tendency to gain weight | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Thick period |
| <input type="checkbox"/> Overweight | <input type="checkbox"/> Polycystic Ovary Syndrome | <input type="checkbox"/> Period contains mucus |

OFFICE USE ONLY (DX: PHLEGM – DAMP ACCUMULATION)
 BBT:
 Follicular phase: temperature is high in the beginning, little of the usual biphasic pattern

 Luteal phase:

 Pulse: slippery, choppy, tight
 Rt. Cun: _____ Guan: _____ Chi: _____ Tongue: white, thick, or greasy coat
 Lt. Cun: _____ Guan: _____ Chi: _____ Body: _____
 _____ Coat: _____

- | | | |
|--|--|--|
| <input type="checkbox"/> Chapped lips | <input type="checkbox"/> Brittle or dry hair | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Dry, flaky skin | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Period is light and/or late |
| <input type="checkbox"/> Brittle fingernails or toenails | <input type="checkbox"/> Diminished nighttime vision | <input type="checkbox"/> Dizziness or light-headedness around time of period |

OFFICE USE ONLY (DX: BLOOD DEFICIENCY [not necessarily equated with anemia])
 BBT:
 Follicular phase:

 Luteal phase:

 Pulse:
 Rt. Cun: _____ Guan: _____ Chi: _____ Tongue:
 Lt. Cun: _____ Guan: _____ Chi: _____ Body: _____
 _____ Coat: _____

- | | | |
|--|--|--|
| <input type="checkbox"/> Rapid pulse rate | <input type="checkbox"/> Wake up sweating/have hot flashes | <input type="checkbox"/> Break out with red acne before period |
| <input type="checkbox"/> Dry mouth and throat | <input type="checkbox"/> Feel warmer than those around you | <input type="checkbox"/> Short menstrual cycle |
| <input type="checkbox"/> Thirsty for cold drinks | <input type="checkbox"/> Vaginal irritation or rashes | |

OFFICE USE ONLY (DX: EXCESS HEAT)
 BBT:
 Follicular phase:

 Luteal phase:

 Pulse:
 Rt. Cun: _____ Guan: _____ Chi: _____ Tongue:
 Lt. Cun: _____ Guan: _____ Chi: _____ Body: _____
 _____ Coat: _____



OFFICE POLICIES

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