Advanced Acupuncture & Chinese Herbal Clinic

Dr. Nikki N. Medghalchy, DAOM, L.Ac., M.Ac., Dip (NCCA) O.M., Janet Lurie
L.Ac. Noriko Hosoyamada DAOM, L. Ac., MAcOM, CST
9411 Hwy. 99, Suite 1, Vancouver, WA 98665
Tel: (360) 571-8515 Fax: (360) 571-8516

Office Use Only **PROVIDER:**	**Date:**
Office Use Only **PATIENT #:** ______________________________ **Age:** ____________	
Patient Please print or type Clearly below	***PATIENT INFORMATION RECORD***
Name:	**Occupation:**
Address:	**Employer:**
City: State: Zip:	**Address:**
Home Phone: ( )	**City: State: Zip:**
Work Phone: ( )	**Subscribers Name:** **Life Partner Name:**
Age:	**Birthdate:**
Sex: M F Birthdate:	**Occupation:**
Referred By: **Email Address:**	**Employer: Phone#:**
Marital Status: M S D W	**Address:**

Primary Insurance Information	***Secondary Insurance Information***
Name:	**Name:**
Address:	**Address:**
City: State: Zip:	**City: State: Zip:**
Phone#: ( )	**Phone#: ( )**
Member#: Grp#:	**Member#: Grp#:**
Insured's Name:	**Insured's Name:**
Relationship: Self Spouse Child Other (circle)	**Relationship: Self Spouse Child Other (circle)**

Account Guarantor: (Work Comp Carrier, Attorney, Etc.)

Phone: ( )

PERSONAL HISTORY

Accident: Injury Illness Gradual Onset Date of Injury/Illness:

Where were you when this first happened:

What is your major complaint:

Work Related? Yes No Were you off work? Yes No If Yes how long?

Patient's Signature: **Date:**

I clearly understand and agree that all services rendered me are charges directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for professional services rendered to me will immediately due and payable.

Nearest relative not living with you (name & phone):

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Welcome to my acupuncture clinic. I look forward to working with you to improve your health. Acupuncture is a holistic medicine that works on physical, mental, emotional and spiritual levels. The purpose of treatment is to bring balance to all of these levels. **Please bring your test result with you.**

PLEASE READ AND SIGN THE FOLLOWING

I voluntarily authorize the acupuncturist to administer acupuncture and/or substances of oriental medicine, for relief of my disorders. ***I understand that appointment times are reserved especially for me and that the $60.00 fee is charged for missed appointments and the $40.00 for same day cancellations.***

I understand that payment is due at the end of each visit, unless otherwise arranged. (*If we are uncertain of your insurance co-pay or coverage, we ask for full payment until this is determined.*) There will be a $35.00 charge on all returned checks.

I have read and understand the above.

SIGNED: ____ DATE: ______________________________

Successful health care and preventive medicine are only possible when the health care practitioner has a complete understanding of the patient; physically, mentally, and emotionally. To assist me in better serving you, please complete the questionnaire as thoroughly as possible. Print all information and mark anything you do not understand with a question mark. All information is strictly confidential. Thank you.

HEALTH HISTORY QUESTIONAIRE

What is your primary concern, condition, injury or illness?____

____

How long has it bothered you?____

Describe what caused it/how it started:____

____

How does this condition affect you? (Interference with work, sleep, appetite, etc.)________________________

____

Have you received treatment for this condition?_______________ When?________________________

From Whom?___________________Diagnosis?____

Results of Treatment?____

Has the condition gotten: Better: ____________ Worse:___________ Same:__________________

Please put a check next to conditions that you have experienced within the last three months. Indicate the length of time you have had this condition:

GENERAL:

☐ Poor Appetite ______	☐ Insomnia ______	☐ Disturbed Sleep ______
☐ Localized Weakness ______	☐ Cravings ______	☐ Strong Thirst ______
☐ Weight Gain ______	☐ Weight Loss ______	☐ Changes in Appetite ______
☐ Sweating Easily ______	☐ Tremors ______	☐ Bleed or Bruise Easily ____
☐ Night Sweats ______	☐ Fever ______	☐ Chills ______
☐ Sudden Energy Drop (time of day?) ______		☐ Poor Balance ______

☐ Other unusual or abnormal conditions you have noticed in your general sense of health?______

SKIN & HAIR:

☐ Rashes ______	☐ Ulcerations ______	☐ Hives ______
☐ Itching ______	☐ Eczema ______	☐ Pimples ______
☐ Dandruff ______	☐ Hair Loss ______	☐ Recent Moles ______

☐ Changes in hair or skin texture __

Any other hair or skin problems? ______

HEAD, EYES, EARS, NOSE, THROAT:

☐ Dizziness ______	☐ Concussions ______	☐ Migraines ______
☐ Glasses ______	☐ Spots in Front of Eyes ______	☐ Eye Pain ______
☐ Poor Vision ______	☐ Night Blindness ______	☐ Color Blindness ______
☐ Cataracts ______	☐ Blurry Vision ______	☐ Earaches ______
☐ Ringing in Ears ______	☐ Poor Hearing ______	☐ Eyestrain ______
☐ Sinus Problems ______	☐ Recurrent Sore Throat ______	☐ Nose Bleeds ______
☐ Grinding Teeth ______	☐ Sores on Lips/Tongue ______	☐ Facial Pain ______
☐ Teeth Problems ______	☐ Headaches ______	☐ Jaw Clicks ______

Any other head or neck problems? ______

CARDIOVASCULAR:

☐ Dizziness ______	☐ Low Blood Pressure ______	☐ Chest Pain ______
☐ Irregular Heartbeat ______	☐ High Blood Pressure ______	☐ Fainting ______
☐ Cold Hands/Feet ______	☐ Swelling of Hands ______	☐ Swelling of Feet ______
☐ Blood Clots ______	☐ Difficulty Breathing ______	☐ Phlebitis ______

Any other heart or blood vessel problems? ______

RESPIRATORY:

☐ Cough ______	☐ Coughing up Blood ______	☐ Asthma ______
☐ Bronchitis ______	☐ Pain w/ Deep Inhalation ______	☐ Pneumonia ______

☐ Difficulty Breathing when Lying Down ______

☐ Production of Phlegm (color?) ______

Any other lung problems? ______

GASTROINTESTINAL:

☐ Nausea ______	☐ Vomiting ______	☐ Diarrhea ______
☐ Constipation ______	☐ Gas ______	☐ Belching ______
☐ Black Stools ______	☐ Blood in Stools ______	☐ Indigestion ______
☐ Bad Breath ______	☐ Rectal Pain ______	☐ Hemorrhoids ______
☐ Abdominal Pain/Cramps ______	☐ Chronic Laxative Use ______	

Any other problems with stomach or intestines? ______

GENITO-URINARY:

☐ Pain on Urination ______	☐ Frequent Urination ______	☐ Blood in Urine ______
☐ Urgency to Urinate ______	☐ Unable to Hold Urine ______	☐ Kidney Stones ______
☐ Decrease in Flow ______	☐ Impotence ______	☐ Sores on genitals ______

Do you wake up at night to urinate? ______ If so, how often? ______

Any particular color to your urine? ______

Any other problems with your genital/urinary functions? ______

REPRODUCTIVE & GYNECOLOGIC:

☐ Menstrual Clots ______	☐ Painful Menses ______	☐ Unusual Menses ______
☐ Changes in body/psyche prior to menstruation ______		Duration ______
☐ Irregular Menses ______	☐ Menopause (Age) ______	☐ Other Problems ______
Age at 1st Menses ______	Time between Menses ______	Duration ______
First day of last Menses ______	# of Pregnancies ______	# of Births ______
Miscarriages ______	Abortions ______	Premature Births ______

Birth Control? ___________________ If so, type? _____________________ How Long? ______________________

MUSCULOSKELETAL:

☐ Neck Pain ___________________ ☐ Muscle Spasms _______________ ☐ Knee Pain _____________________
☐ Back Pain ____________________ ☐ Muscle Weakness _____________ ☐ Foot/Ankle Pain ________________
☐ Hand/Wrist Pain ______________ ☐ Shoulder Pain ________________ ☐ Hip Pain ______________________

Any other joint/bone problems? ____________________________________

NEUROPSYCHOLOGICAL:

☐ Seizures _____________________ ☐ Dizziness ____________________ ☐ Loss of Balance ________________
☐ Area of Numbness _____________ ☐ Poor Memory _________________ ☐ Lack of Coordination ____________
☐ Concussion ___________________ ☐ Depression ___________________ ☐ Anxiety _______________________
☐ Bad Temper __________________ ☐ Easily Susceptible to Stress ______

Have you ever been treated for emotional problems? ____
Have you ever considered or attempted suicide? ____
Any other neurological/psychological problems? ____

LIFESTYLE:

Do you follow a regular exercise program? ____
Please describe your average daily diet: ____

____

☐ Cigarette Smoking _________ ☐ Coffee, Tea & Cola _______☐ Alcoholic Beverages _____________________

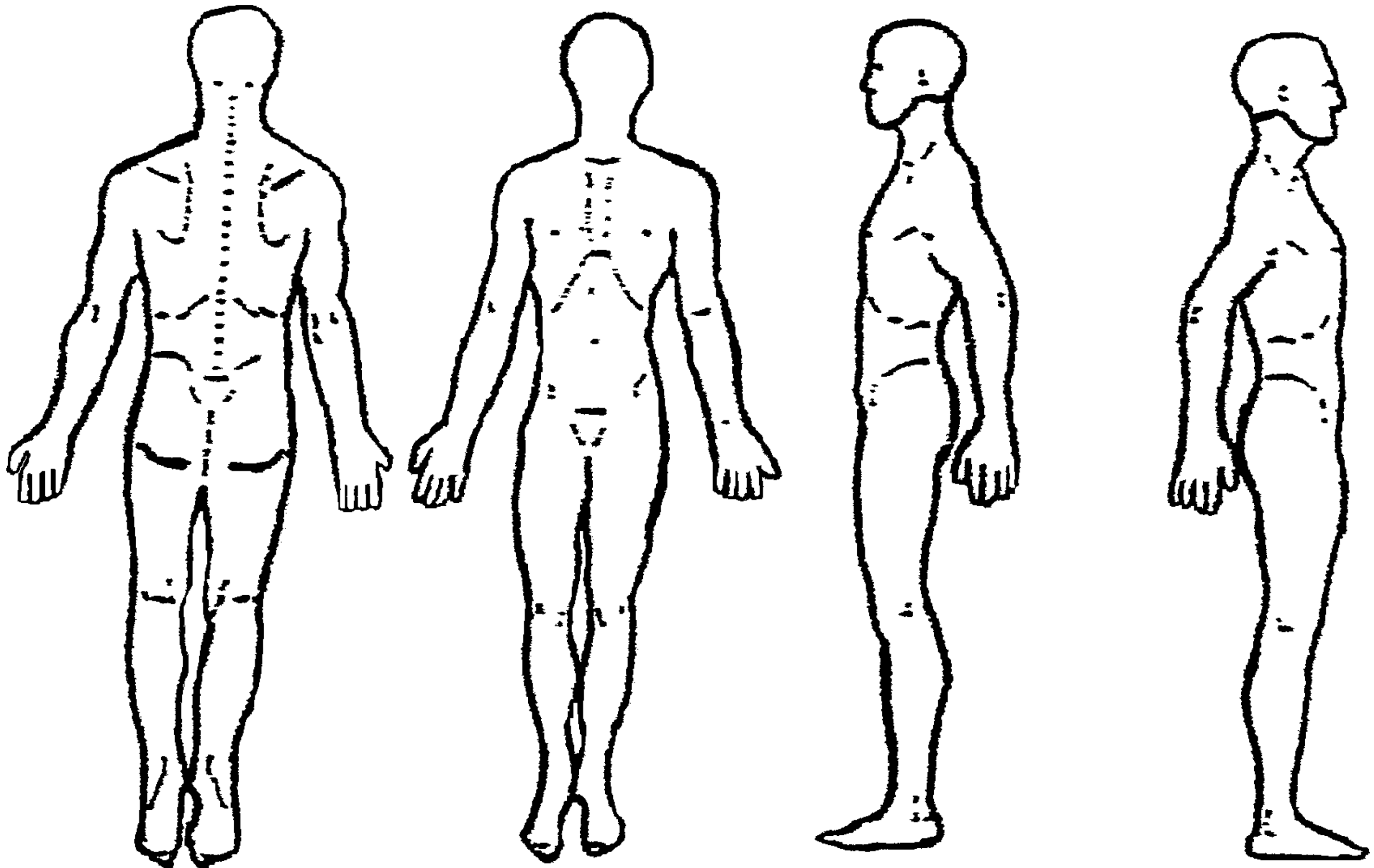
Medications taken within the last two months (vitamins, drugs, herbs, etc.): _____________________________

____

Please describe any use of drugs for non-medicinal purposes: ____

____

INDICATE PAINFUL OR DISTRESSES AREAS:



PATIENT CONSENT FORM

Dr. Nikki Nooshin Medghalchy is a licensed acupuncturist in the: State of Washington: License number 029501, dated 11/5/99; State of Oregon: License number AC00502, dated 10/20/00. She received her Doctoral degree and Master of Science degree in Acupuncture and Oriental Medicine from Oregon School of Oriental Medicine in Portland, OR, in June of 1999 and Sep. 2007. Her didactic and clinical training was completed between 1993 and 2007.

Washington law requires that each patient be informed regarding the scope of practice in which a licensed acupuncturist is allowed to engage, which included but is not limited to the following techniques:

1) Use of acupuncture needles to stimulate acupuncture points and meridians;
2) Use of electrical, mechanical or magnetic devices to stimulate acupuncture points and meridians;
3) Moxibustion;
4) Acupressure;
5) Cupping;
6) Dermal Friction (gwa has);
7) Infra-red;
8) Sonopuncture;
9) Laserpuncture;
10) Dietary advice based on Traditional Chinese medical theory; and
11) Point injection therapy (aquapuncture).

Side effects may occur in a small percentage of patients and may include the following: some pain following treatment in the insertion area, minor bruising, infection, needle sickness (fainting), and broken needle.

IF YOU HAVE A SEVERE BLEEDING DISORDER OR HAVE A PACEMAKER, YOU SHOULD MAKE THAT INFORMATION KNOWN TO YOUR PRACTITIONER PRIOR TO TREATMENT.

I have read and understood the above information.

Signed:_____________________________________ Date:_________________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly;
- Obtain payment from third-party payers for my health services; and
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my acupuncture provider's ***NOTICE OF PRIVACY PRACTICES*** containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such ***NOTICE OF PRIVACY PRACTICES***. I understand that my acupuncture provider has the right to change the ***NOTICE OF PRIVACY PRACTICES*** and that I may contact this office at the address above to obtain a current copy of the ***NOTICE OF PRIVACY PRACTICES***.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME:______________________________________
DATE:________________________

SIGNATURE:____
RELATIONSHIP TO PATIENT:___________________________

Dependent family members also covered by this acknowledgement:

____

____

____

For office use only: We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason(s):

- Patient refused to sign
- Communications barriers
- Emergency situation
- other