



Advanced Acupuncture Inc. II
 Dr. Nikki N. Medghalchy, L.Ac., M.Ac., Dip (NCCA) O.M
 Mr. Robert J. Williams, L.Ac, MAcOM
 375 N. State Street, Lake Oswego, Oregon 97034
 Tel: (503) 908-0157 Fax: (503) 908-0187



<i>Office Use Only</i> PROVIDER: _____		Date: _____
<i>Office Use Only</i> PATIENT #: _____		Age: _____
<i>Patient Please print or type Clearly below</i> PATIENT INFORMATION RECORD		
Name: _____		Occupation: _____
Address: _____		Employer: _____
City: _____	State: _____	Zip: _____
Home Phone: () _____		City: _____
		State: _____
		Zip: _____
Work Phone: () _____		Spouse's Name: _____
		S/O Name: _____
Age: _____		Birthdate: _____
Sex: M F	Birthdate: _____	
Referred By: _____		Occupation: _____
Email Address: _____		Employer: _____
		Phone#: _____
Marital Status: M S D W		Address: _____
Primary Insurance Information		Secondary Insurance Information
Name: _____		Name: _____
Address: _____		Address: _____
City: _____	State: _____	Zip: _____
Phone#: () _____		City: _____
		State: _____
		Zip: _____
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: (or Guardian, if Minor): _____		Date: _____
<i>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.</i>		
Nearest relative not living with you (name & phone): _____		



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Patient's Signature (or Guardian, if Minor): _____

Date: _____

Welcome to Advanced Acupuncture Inc. II clinic. We 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 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 \$40.00 fee is charged for missed appointments and the \$20.00 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 QUESTIONNAIRE

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 _____
- Localized Weakness _____
- Weight Gain _____
- Sweating Easily _____
- Night Sweats _____
- Sudden Energy Drop (time of day?) _____
- Other unusual or abnormal conditions you have noticed in your general sense of health? _____
- Insomnia _____
- Cravings _____
- Weight Loss _____
- Tremors _____
- Fever _____
- Disturbed Sleep _____
- Strong Thirst _____
- Changes in Appetite _____
- Bleed or Bruise Easily _____
- Chills _____
- Poor Balance _____

SKIN & HAIR:

- Rashes _____
- Itching _____
- Dandruff _____
- Changes in hair or skin texture _____
- Ulcerations _____
- Eczema _____
- Hair Loss _____
- Hives _____
- Pimples _____
- Recent Moles _____

Any other hair or skin problems? _____

HEAD, EYES, EARS, NOSE, THROAT:

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

Any other head or neck problems? _____

CARDIOVASCULAR:

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

Any other heart or blood vessel problems? _____

RESPIRATORY:

- Cough _____
- Bronchitis _____
- Difficulty Breathing when Lying Down _____
- Production of Phlegm (color?) _____
- Coughing up Blood _____
- Pain w/ Deep Inhalation _____
- Asthma _____
- Pneumonia _____

Any other lung problems? _____

GASTROINTESTINAL:

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

Any other problems with stomach or intestines? _____

GENITO-URINARY:

- Pain on Urination _____
- Urgency to Urinate _____
- Decrease in Flow _____
- Frequent Urination _____
- Unable to Hold Urine _____
- Impotence _____
- Blood in Urine _____
- Kidney Stones _____
- 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 _____
- Changes in body/psyche prior to menstruation _____
- Irregular Menses _____
- Age at 1st Menses _____
- First day of last Menses _____
- Miscarriages _____
- Painful Menses _____
- Menopause (Age) _____
- Menopause (Age) _____
- Time between Menses _____
- # of Pregnancies _____
- Abortions _____
- Unusual Menses _____
- Duration _____
- Other Problems _____
- Duration _____
- # of Births _____
- Premature Births _____

Birth Control? _____ If so, type? _____ How Long? _____

MUSCULOSKELETAL:

- Neck Pain _____
- Back Pain _____
- Hand/Wrist Pain _____
- Muscle Spasms _____
- Muscle Weakness _____
- Shoulder Pain _____
- Knee Pain _____
- Foot/Ankle Pain _____
- Hip Pain _____

Any other joint/bone problems? _____

NEUROPSYCHOLOGICAL:

- Seizures _____
- Area of Numbness _____
- Concussion _____
- Bad Temper _____
- Dizziness _____
- Poor Memory _____
- Depression _____
- Easily Susceptible to Stress _____
- Loss of Balance _____
- Lack of Coordination _____
- Anxiety _____

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: _____

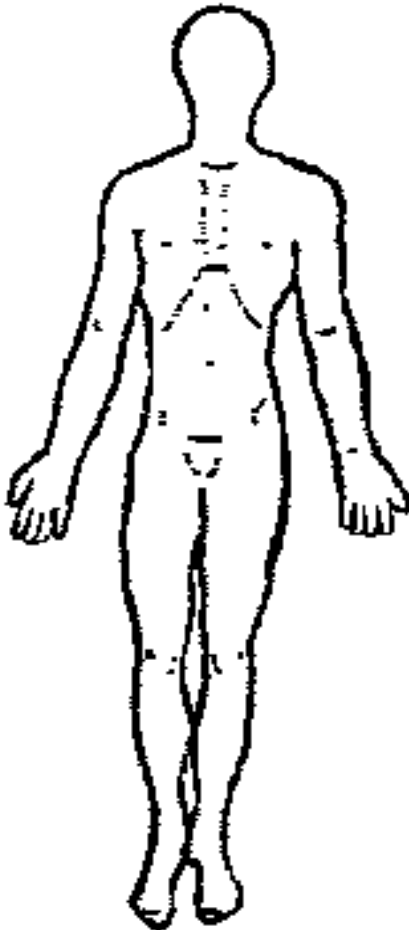
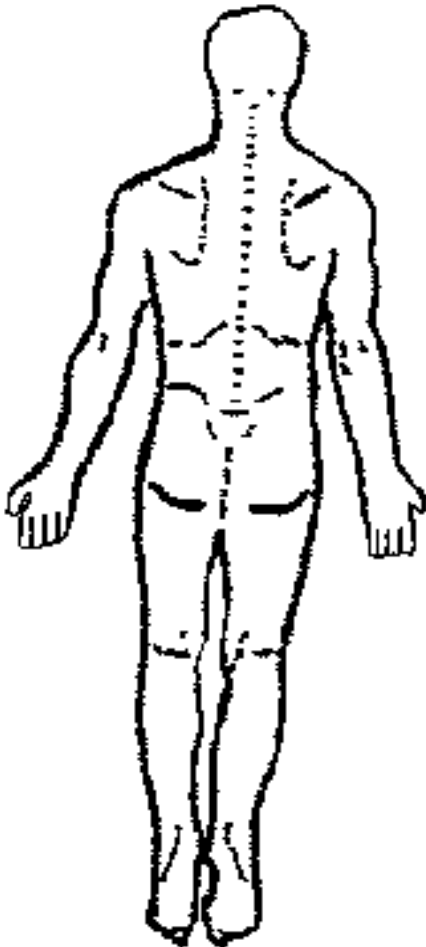
INDICATE PAINFUL OR DISTRESSES AREAS:

BACK

FRONT

LEFT

RIGHT



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.

Mrs. Lindsay Matthews is a licensed acupuncturist in the state of Oregon: License number AC01253, dated 01/05/09. She received her Masters degree in Acupuncture and Oriental Medicine from the Oregon College of Oriental Medicine in Portland, OR in August 2009.

Washington and Oregon law require 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) Moxabustion;
- 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 (HIPPA). 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