Advanced Acupuncture & Chinese Herbal Clinic

Dr. Nikki N. Medghalchy, L.Ac., M.Ac., Dip (NCCA) O.M., Dr. Ed Chiu L.Ac,
Janet Lurie L.Ac. Dr. Noriko Hosoyamada 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: ( )	**Spouse's Name:** **S/O Name:**
Age:	**Birthdate:**
Sex: M F Birthdate:	**Occupation:**
Referred By:	**Employer:**
Email Address:	**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: (or Guardian, if Minor): 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):

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

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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 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 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? ______________________

MUSCLOSKELETAL:

☐ 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.): ________________________________

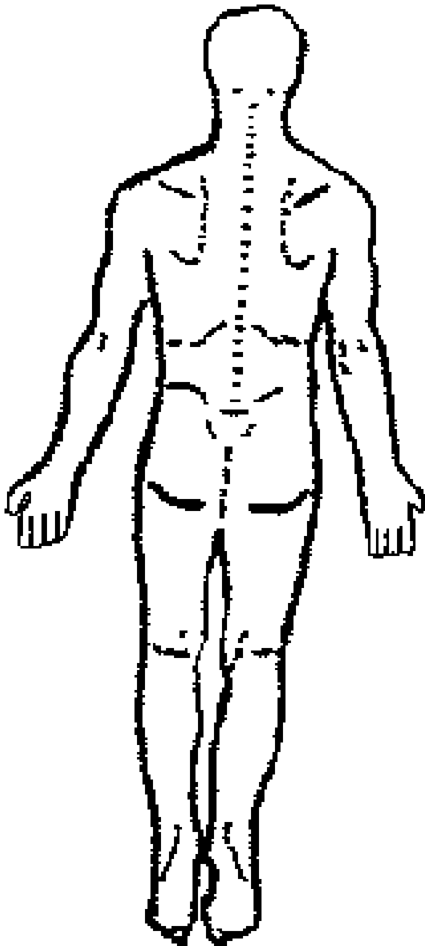
____

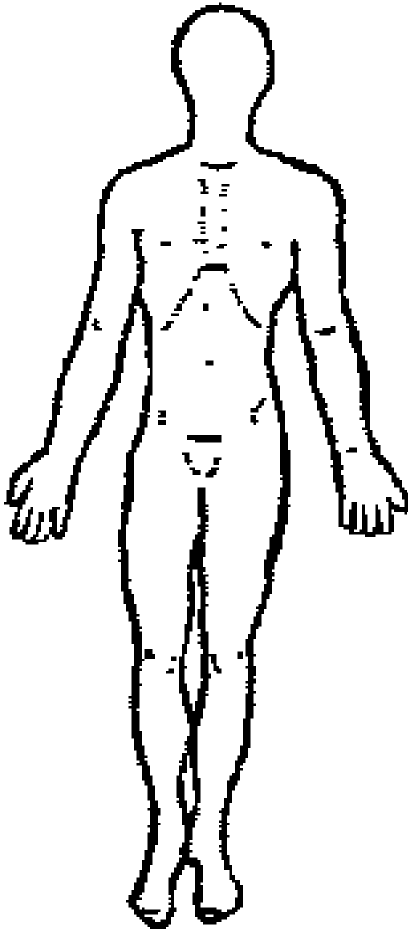
Please describe any use of drugs for non-medicinal purposes: ____

____

INDICATE PAINFUL OR DISTRESSES AREAS:

BACK **FRONT** **LEFT** **RIGHT**





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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:________________

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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