Patient Registration Form

Today's Date:	◯ Female ◯ Male	Date of Birth:
Name	Last) First)	
Street Address:		
City:	State:	Zip Code:
Phone #	□**Cell** □**Home**	Emergency Contact (Name & Phone #)
Occupation	☐ single ☐ Married ☐ Divorced ☐ Widowed ☐ separated	
Email		
Weight	_____**lbs**	Height _____**ft**_____**in (**_____**cm)**

What is your main complain(s)?_____

How it happened? _____

When did this condition begin? (onset date) _____

If the discomfort radiates, where does travel to? _____

Severity of your pain:(0 = no pain / 10 = severe pain) [0 1 2 3 4 5 6 7 8 9 10]

Frequency of pain: □ Constant (100%) □ Frequent (75%) □ Intermittent (50%) □ Occasional (25%)
□ On and off □ Random □ Recurring

How would you describe your pain? (check all the apply)

□ Aching □ Burning □ Dull □ Pulling □ Sharp
□ Stiffness □ Throbbing □ Tightness □ Shock like □ Tingling
□ Stabbing □ Tearing □ Miserable □ Shooting □ Deep/penetrating
□ Pins & needles □ Intolerable □ Spasm □ Other _____

Symptom relieved by?

□ Cold packs □ exercise □ heat pack □ massage □ nothing
□ rest □ stretching □ Chiropractic □ Acupuncture □ Physical Therapy
□ Other _____

What aggravates the symptoms?

_____

Mood: ◯ Optimistic ◯ Happy ◯ Calm ◯ Agitated ◯ Anxious ◯ Depressed ◯ Anger

Previous episodes? □ Yes □ No

if yes, how long ago? _____

What treatment have you received for the above conditions(s)?

□Surgery □ Medications □ Physical Therapy □Chiropractic □ Massage □ Injections
□ MRI □ X-Ray □ CT scan□ Others: _____

List any medications, prescriptions, vitamins, or over the counter items you are taking or had taken in the past 3 months and their purpose:

Are you allergic to any medications? Yes _____ No_____
If Yes, please list them

Are you currently receiving any treatments(S)?□ No □ Yes_____

Activity of daily living most affected?
□ Sleeping □ Walking □ Driving □ Self-care (washing, dressing, grooming, etc) □ Others: _____

Who can we thank for referring you to our clinic?
□ Yelp □ Google □ Friends/Family □ Health Insurance □ etc: _____

Personal Health History (check all symptoms you had/have)

Child hood illness:

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
□	□	Measles	□	□	Mumps	□	□	Rubella	□	□	Chickenpox	□	□	Rheumatic Fever
Had	**Have**		**Had**	**Have**										
□	□	Polio	□	□	Others _____									

Personal Health History (check all symptoms you had/have)

List any and all medical problems and the year that you were diagnosed with:

Communicable Disease_____ Bleeding Disorder_____
Cancer_____ Depression_____
Diabetes _____ heart Problems _____
High Blood Pressure _____ Thyroid Problems _____
Others: _____

General Symptom (check all symptoms you had/have)

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
□	□	Poor appetite	□	□	Have appetite	□	□	Cravings	□	□	Sweats easily	□	□	poor sleep
Had	**Have**		**Had**	**Have**		**Had**	**Have**		**Had**	**Have**		**Had**	**Have**	
□	□	Chills	□	□	Bleed or bruise	□	□	cold hands or feet	□	□	Poor circulation	□	□	Vertigo or dizziness
Had	**Have**		**Had**	**Have**		**Had**	**Have**		**Had**	**Have**				
□	□	Fatigue	□	□	Lack of strength	□	□	Shortness of breath	□	□	Muscle cramps			

Past Health History

Surgery / Hospitalization History

Year	Surgeries / Hospitalizations	Complications

Women Only

Are you currently pregnant?□ No □ Yes : If yes, how many month?_____

Women Only (check all symptoms you had/have)

Female: Menstruation □Regular □Irregular Cycle : Every days / Lasts days
Blood Amount: □Heavy □ Normal □ Scanty □ Clear **Color**: □ Bright Red □ Dark Red □Brown □Pink
Leucorrhea : □heavy □thick □yellow □foul smell □scanty □thin □clear
How many? Children ___ Miscarriage ___ Abortion ___ C-section___

Women's Health

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
□	□	Fibroids	□	□	Ovarian Cysts	□	□	Endometriosis	□	□	PCOS	□	□	An-Ovulation
Had	**Have**		**Had**	**Have**		**Had**	**Have**		**Had**	**Have**		**Had**	**Have**	

□□ Blocked Tubes □□Pelvic Inflammation

Past Accidents or Trauma: □ None

Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
□□Slip/fall		□□Fracture		□□Bicycle accident		□□Motorcycle accident		□□Pedestrian	
□□ Car accident		□□Others_____							

Family History: (examples: diabetes, arthritis, cancer, hypertension, stoke, seizures, gout, blood clots kidney, liver, heart diseases)

Allergy_____ Bleeding Disorder_____

Cancer_____ Depression_____

Diabetes_____ Heart Problems _____

High Blood Pressure _____ Other_____

Primary Insurance (If you have an health insurance, give us Insurance Card & your ID for verification)

Insurance Company_____

Secondary Insurance (□Check her if you do not have Secondary Insurance)

Insurance Company_____

Work History:

□Full time □Part time □Homemaker □Retired □Student □Unemployed □Fully or Partially disabled

How many hours do you work per week? (average) _____

□Mostly sitting □Standing □Walking □Light labor □Moderate labor □Heavy labor □Sedentary

□Computer □Repetitive □Telephone □Difficult □Enjoyable □Relaxed □Stressful

Social History: (Your health habits and stress levels)

Alcohol use □Never □Social drinker □Light drinker □Moderate drinker □Heavy drinker □An Alcoholic □Recovering Alcoholic

Tobacco use □Never □Social smoker □Light smoker □Every day smoker □Heavy drinker □Ex-smoker □Unknown

Coffee use □Never □1 cup in the morning □2-4 cups every day □5 or more cups every day

Water intake How much? _____ Pain relievers □None How much? _____

Soft drinks How much? _____ Recreational drugs □None How much? _____

Exercising □Never □Every day □Every other day □Few times a week □Once a week

What kinds of exercise do you do?

_____

Diet/nutrition □Controlled, restricted, balanced diet □Diabetic diet □Gluten free diet □Vegetarian, vegan, raw food diet

How many meals a day? _____

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture, alternative medicine, herbs and other substances by a licensed acupuncturist in this clinic.

_____. **Acupuncture**:I understand that acupuncture is performed by the insertion of needles through the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, numbness, minor bleeding, fainting, pain or discomfort and the possible aggravation of symptoms existing prior to acupuncture treatment. Other unusual but rare risks include lung or organ puncture, nerve damage, and spontaneous miscarriage. I understand that no guarantees concerning its use and effects are given to me and that I may stop acupuncture treatment at any time.

_____.**Moxibustion**:I understand that if I receive moxibustion (heat therapy) as part of therapy, there is a risk of burning with the use of direct moxibustion burning and/or scarring may result from its use. I understand that I may refuse either of these therapies.

_____.**Cupping**: I understand that if I receive cupping as part of therapy, it is involves a localized suction produced by heating a small glass cup. there is a risk of tenderness, redness, bruising, blistering, and/or scarring. I understand that I may refuse this therapy..

_____.**Scraping/Guasa** It involves scraping over a small area by using a smooth- edged instrument. There is a possibility that local bruising is likely
to occur at the site where GuaSha is perfumed.

_____.**Tapping, Plum Blossom, Bleeing Pricking** All involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment site are a likely occurrence. Only single-use needles are used in these procedures.

_____.**Herbs & Supplements**:I understand that herbs and supplements may be recommended to me to treat bodily dysfunctions, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movements, abdominal pain/discomfort, nausea/vomiting, rashes and possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems which I associate with these substances, I will suspend taking them and call my acupuncturist as soon as possible.

_____.**Acupressure/TuiNa/Manual Therapy** it involves rubbing, kneading, pressing, and stroking, etc., which may result in muscle soreness at the massage site that can last several days. This technique may require disrobing. I understand all attempts will be made to assure my privacy.

_____. **Electro Acupuncture**:I understand that I may be asked to have electro acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

_____.**Nutritional and Lifestyle Counseling**:I understand that the practitioner neither claims nor implies that any instruction, advice, recommendations, services, or herbal/nutritional products the practitioner provides or recommends will cure, treat, prevent or mitigate any disease condition, but are provided solely for the purpose of nourishing and strengthening the natural function of the various body organs and systems so that they may have a greater capacity to heal themselves. I understand that the practitioner believes many diseases are related to unresolved emotional conflicts. I understand that counseling or assistance offered in this area is done on a spiritual basis and does not replace licensed psychiatric care or professional counseling. I request the advice and assistance of this practitioner in helping me to learn what I can do to improve my health and fitness. I request this information and any products or services that may attend it as my right to Freedom of Choice in Medicine and Health care retained by me under the Ninth Amendment to the U.S. Constitution, of certain rights, shall not be construed to deny or disparage others retained by this person.

I understand that the acupuncture practitioner must be advised if I have a **pacemaker, cardiac condition, bleeding disorder, history of seizures, on blood thinners** (Coumadin, Warfarin, etc.), or if I am or may be **pregnant**. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. If I have not already done so, I agree to consult with a medical doctor for any serious or life threatening disease or condition either for myself or those under my guardianship.

I have carefully read and understand all information contained within this consent to treatment form and I am fully aware of what I am signing.

Patient Signature: _____ **Date:** _____

Guardian's Signature: _____ **Date:** _____

Cancellation, Missed Appointment and Late Arrival Policy

We do our best to take care of each patient in their scheduled appointment time. Please review our policy so that you can help us in providing the best care possible. Reminder text messages are sent out as a courtesy to our patients. Please bear in mind that you are still responsible for the appointment.

Cancellations: If you are unable to keep your scheduled appointment, please give us **24 hour notice**. Our office phone number is (480) 810-7960. If you reach our voicemail after hours, please leave a detailed message for us. If you would like to reschedule your appointment, please leave a phone number and we will contact you as soon as possible.

Missed Appointment/No Show/Late Arrivals: We understand that emergencies and inclement weather happen, and we would like for you to let us know if something prevents you from being here. However, appointments that are missed without notice (no call/no show), are more than 15 minutes late (without notice), or same-day cancellations (except in emergency cases) will be subject to the following:

- A $50 charge will be added to patient account if canceled within 24 hours of appointment.
- If a patient consecutively set & cancels 3 appointments without attending, a $100 charge will be incurred.
- If a patient does not call or show up for their appointment a $90 charge will be incurred.
  *All charges must be paid before treatment will be continued.

  * Shanghai Chinese Medicine and Acupuncture reserves the right to amend these policies or make special considerations. Supporting documents may be required for special considerations.

Package Policy

Packages are purchased and discounted in sessions of 5 and 10. If a patient chooses to cancel an on-going, pre-paid package, they will be charged either the value of the closest matched package or full price for each session attended (e.g. If a 10 holistic package is purchased at a discount of $130/visit and only 3 visits are attended before cancellation, the patient will be charged full price of $150 for 3 visits and refunded the remainder. If 5 visits were attended before cancellation, the patient will be charged the price of a 5 package for $135 visit with the remainder refunded).

All packages must be used within 1 year of purchase. *Special circumstances may be approved

Packages are transferable to another person upon approved request, however, treatment value must be matched (e.g. If new patient receives treatment $180 above package cost $130 for the new patient visit, they must pay the remainder of the new patient visit cost $50)

All refunds will be given in the manner in which they are received. Cash will be refunded via check

I have read the policy above. I understand and agree to abide by the listed terms.

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Financial Policy

[Personal Injury Case]

Patient who doesn't disclose or knowingly not telling the truth about personal injury (PI) case and received treatment as regular self-pay patient in purpose of getting more settlement for themselves, will be billed again as personal injury using correct fee schedule like should have been done in the first place. **When we treated the patient as regular patient and request for our medical record to be used in PI case or in ligation, patient need to sign doctor's lien, agreement to pay off the whole PI bill, and authorization to release medical record before receiving the medical record.**

[Responsibility for Payment]

As courtesy to you, we will gladly submit your charges to your insurance company; however, all services rendered by this office are charged directly to you, and ultimately, you are personally responsible for payment of these charges regardless of any insurance reimbursement or settlement you may or may not receive.

I have read the policy above. I understand and agree to abide by the listed terms.

[Payment Methods Accepted]

Shanghai Chinese Medicine and Acupuncture accepts payments through credit card, cash, check, Health Saving Account (HAS) and Flexible Spending Accounts (FSA). For a check that is bounced, a $25 fee will be collected.

Shanghai Chinese Medicine and Acupuncture reserves the right to refuse service and treatment to anyone at any time. Additionally, Shanghai Chinese Medicine reserves the right to cancel on-going, pre-paid treatment & will only refund treatments not received.

Shanghai Chinese Medicine and Acupuncture will collect payment for all services rendered.

Patient Signature: _____ **Date:**