GENERAL INFORMATION

Full Name: ______________________________ Date of Birth: __________________ Male Female

Address: ___________________________ City: ___________________ State: ________ Zip: __________

Phone: Home_______________ Mobile_______________ Email: ____________________________

Marital Status: __________________

Employer/Occupation: ______________________________ Work Phone: _______________________

Emergency Contact: ______________________________ Phone: ____________________________

Primary Physician: ______________________________ Phone: ____________ May we contact them? Y N

Who referred you (How did you hear about us)? ____

PRIMARY INSURANCE INFORMATION *(health insurance, auto insurance, workers compensation, etc)*

Insurance Company: ____

Address: ___________________________ City: ___________________ State: _____ Zip: _______________

ID/Claim # (include alpha prefix): _________________________ Group/Policy #: ______________________

Name of Insured (if other than you): ____

Relationship to insured: __________________ Insured's Date of Birth: ______________ Male Female

Adjuster's name: ____________________ Phone: ________________ Fax: ______________________

SECONDARY INSURANCE INFORMATION *(if you have other insurance)*

Insurance Company: ____

Address: ___________________________ City: ____________ State: ________ Zip: _________

ID/Claim # (include alpha prefix): ____________________ Group Plan/Policy #: _______________

Name of Insured (if other than you): ____

Relationship to insured: _______________________ Insured's Date of Birth: ___________ Male Female

Adjuster's name: __________________________ Phone: _______________ Fax: ____________

MOTOR VEHICLE ACCIDENT (MVA) *(additional information necessary if applicable - auto insurance)* Accident occurred in what state? __________ On: date _________ time ___________

Job related accident? No Yes

Did you report the accident to the insurance company? No Yes (to whom) ____________________

Did you submit the "Application of No-Fault Benefits" to your insurance company? No Yes, date _____________

Attorney Name (if applicable): ____

Address: City: ___________________________ State: ________ Zip: ______________

Phone: _________________ Fax: ____________________ Email: ________________________

OFFICE USE ONLY

Rev. 06/19/2023

COMMUNICATION/APPOINTMENT REMINDERS

The preferred method(s) of communication completed and signature on page 2 authorizes the office staff/practitioner(s) to notify you regarding your appointments or for other communications/information related to the office.

Text (mobile number):___________________________________

Email: ____

Telephone: same as mobile_______________________________

Type: home ______________work_________________________

Postal Mail: same as on registration _______________________

L

I

CANCELLATION

A 24-hour notice is required for cancellation of an appointment or you may be charged a $40 cancellation fee for the appointment. Payment is due before your next appointment.

We do not bill insurance companies for missed appointments or late cancellations. You are responsible for paying the missed appointment/late cancellation fees.

TARDINESS

Appointment times are as scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please be on time to your appointment.

SICKNESS

Please cancel your appointment as soon as you are aware of an infectious or contagious condition. If it is within the 24-hour notice period, the cancellation fee may be waived.

FINANCIAL RESPONSIBILITY

Payment is required in full for services rendered at the time of visit unless other arrangements have been made. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and other expenses incurred in collecting on the practitioner(s) account.

Once your insurance is verified, we will bill and accept payment from your insurance company for covered services. In the event the insurance company denies payment or makes partial payment, you are responsible for the balance, deductibles, and co-pays. Your signature on this page confirms your financial responsibility for all services regardless of insurance reimbursement.

B

ASSIGNMENT OF BENEFITS

Your signature on this page authorizes and directs payment of medical benefits to the practitioner(s) for services provided by this office.

RELEASE OF MEDICAL RECORDS

Your signature on this page authorizes the release of all your/your child/dependents medical records on file in this office, for the purpose of processing claims, to the following: your attorney, the healthcare providers attending to this condition, and the insurance case managers. Medical records will not be edited unless otherwise stated in an exclusive release of medical records signed through your attorney.

S

AUTHORIZING SIGNATURE

______________________ ____

Date Patient/Client/Parent/Guardian *SIGNATURE*

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

I hereby request and consent to the performance of Acupuncture and other Oriental Medicine procedures by the acupuncturist named below. **I understand that I am not receiving a western medical diagnosis and that any health concerns that I may have should be consulted with by my primary medical doctor.**

I understand that methods of treatment may include acupuncture, moxibustion, cupping, Gua Sha, electrical stimulation, Far Infrared Therapy, breathing techniques, exercise therapy, Tui-na (Chinese massage), herbs and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Rare and unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this site uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. Bruising is a common side effect of cupping.

The herbs and nutritional supplements (from plant, animal and mineral sources), which may be recommended, are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives and tingling of the tongue.

I will notify the clinical staff member who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known in my best interest. I understand that results are not guaranteed.

Privacy Notice

This office follows all the rules of HIPPA as related to privacy. I understand that my health information will be used only to carry out treatment and for health operations such as appointments and collecting payment. I agree that notes may be mailed to my address or phone messages may be left at my home. I understand that I have the right to request how my personal information is used. I understand that I have the right to revoke consent at any time for all future transactions. I understand that I am being treated in a small office and that all reasonable measures are taken to protect my privacy. The office reserves the right to change its privacy policies in accordance with applicable law.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment. I do affirm that I have been advised to consult a physician regarding the condition or conditions for which I am seeking acupuncture treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

AUTHORIZING SIGNATURE

______________________ ____

Date Patient/Client/Parent/Guardian *SIGNATURE*

All Services Provided by: Dr. Karen Williams, DACM, L.Ac., Diplomate O.M.

FOCUS

What is the primary reason for seeking care in our office?

____

When did it start? ___________________________ Sudden or gradual onset (circle)

If you were given a Western diagnosis please list____________________________________

What makes it better? ____

What makes it worse? ____

SIGNS/SYMPTOMS/CONDITIONS *(P = past, C = current)*

Past & Present Condition (PLEASE CIRCLE ALL THAT APPLY)

___AIDS/HIV ___Diabetes ___High Blood Pressure ___Rheumatic Fever

___Alcoholism ___Emphysema ___Measles ___Anemia___Eye Disease

___Allergies ___Epilepsy ___Multiple Sclerosis ___Seizures

___Skin conditions, rashes ___ Goiter ___Mumps ___Stroke

___Depression ___Gout ___ Pacemaker ___Thyroid disorder

___Asthma ___Heart disease ___Uncontrolled Bleeding ___Ulcer

___Cancer ___Hepatitis __ _Pneumonia ___Venereal Disease

___Drug Abuse ___Kidney/ Bladder Issues ___Liver disease _____________________________Other

Are you currently pregnant? Yes or no (please circle one)

MEDICAL HISTORY

Do you have allergies or sensitivities? Please explain: ____

Current Medications Vitamins/Supplements:

____

____

Surgeries (list with dates)

____

____

Trauma: Falls/injuries/accidents, etc. (list with dates):

____

____

SYMPTOMS & PAIN

Identify CURRENT symptomatic areas in your body by marking letters on the figures:

Musculoskeletal
Please mark on the diagram areas of discomfort

Sharp Pain
☐ Dull Pain
☐ Constant Pain
☐ Shooting Pain

Please rate the pain intensity on a scale of 1 ➔ 10 (10 is highest)

____

*can also indicate # on diagram

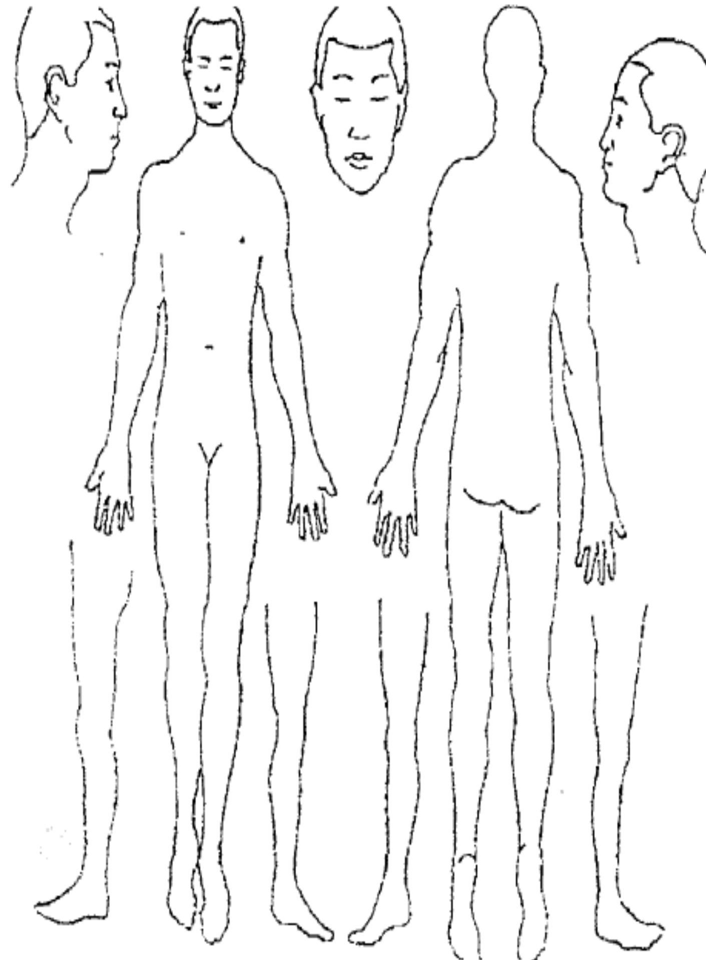
What decreases the pain?

____

What causes the pain to increase?

____

OTHER:
☐ Tingling
☐ Itching
☐ Numbness
☐ Neuropathy
☐ Tension/Tightness
☐ Limited Range of Motion
☐ Limited Use



Explain:

How often do you experience them during the day? Intermittent *(0-25%)* Occasional *(26-50%)* Frequent *(51-75%)* Constant *(76-100%)*

Describe the nature of your symptoms? Sharp Shooting Dull Ache Burning Numb Tingling

How are your symptoms changing? Improving Same Getting worse

What activities do your symptoms interfere with? Work Sleep Walking Sitting Standing Bending Stretching

RATING SCALE (1-10, 1 being nothing and 10 being most severe)

Symptoms at their worst: **1 2 3 4 5 6 7 8 9 10** Symptoms at their best: **1 2 3 4 5 6 7 8 9 10**

How symptoms affect your ability to perform daily activities: **1 2 3 4 5 6 7 8 9 10**
Pain level TODAY: **1 2 3 4 5 6 7 8 9 10**