CHAH
• ACUTHERAPY •

"The doctor of the future will give no medicine, but will interest patients in the care of the human frame, in diet, and in the cause and prevention of disease."
- Thomas Edison

New Patient Information

Name _____ Today's Date _____

Address _____ Apt. _____

City _____ State _____ Zip _____

Preferred Phone _____ Email _____

Birth Date (mm/dd/yy) _____ Age _____ Gender _____

Occupation _____ Employer _____

Referred by _____

Emergency Contact: Name _____ Phone _____

Health History

Have you had acupuncture before? _____ Did it help you? _____

Main issue(s) you are seeking treatment for:

1.) _____

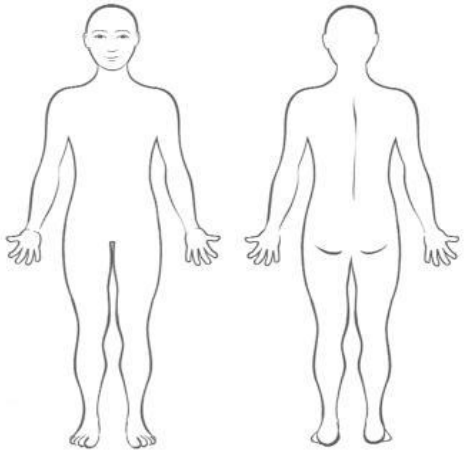
2.) _____

3.) _____

How long have you been suffering from these problems? _____

Do your present issues impair your daily activities? _____

Please mark any areas of pain or discomfort:



Please check any symptoms that you have experienced in the past or currently experience:

General

	past	current		past	current
sweating easily during the day	☐	☐	fatigue	☐	☐
fevers	☐	☐	chills	☐	☐
bleed or bruise easily	☐	☐	poor sleep	☐	☐
weight loss/gain	☐	☐	dizziness/vertigo	☐	☐

Skin & Hair

	past	current		past	current
rashes/hives	☐	☐	psoriasis	☐	☐
eczema	☐	☐	loss of hair	☐	☐
acne	☐	☐			

Head, Ears, Eyes, Nose & Throat

	past	current		past	current
earaches/pressure in the ears	☐	☐	headaches/migraines	☐	☐
ringing in the ears	☐	☐	sinus pressure	☐	☐
hearing loss	☐	☐	nose bleeds	☐	☐
eye floaters	☐	☐	swollen lymph nodes	☐	☐
itchy eyes	☐	☐	teeth/jaw clenching	☐	☐
blurry vision	☐	☐			

Cardiovascular/Circulatory

	past	current		past	current
chest pain	☐	☐	swelling/edema	☐	☐
fainting	☐	☐	high blood pressure	☐	☐
lightheadedness	☐	☐	low blood pressure	☐	☐
cold hands & feet	☐	☐	palpitations	☐	☐

Respiratory

	past	current		past	current
pain on inhaling	☐	☐	sneezing	☐	☐
chest tightness	☐	☐	seasonal/other allergies	☐	☐
cough	☐	☐	phlegm production	☐	☐
asthma	☐	☐	shortness of breath	☐	☐
difficulty breathing	☐	☐			

Genito-Urinary

	past	current		past	current
difficulty urinating	☐	☐	urgent/frequent urination	☐	☐
blood in urine	☐	☐	sores on genitals	☐	☐
pain upon urination	☐	☐	genital pain	☐	☐

Neurological/Psychological

	past	current		past	current
anxiety	☐	☐	poor memory	☐	☐
depression	☐	☐	quick temper	☐	☐
loss of balance/coordination	☐	☐	easily stressed	☐	☐
areas of numbness/paralysis	☐	☐	irritability	☐	☐

Digestive

	past	current		past	current
heartburn	☐	☐	gas	☐	☐
belching	☐	☐	diarrhea	☐	☐
bloating	☐	☐	constipation	☐	☐
nausea	☐	☐	abdominal pain/cramps	☐	☐
vomiting	☐	☐	mucus in stool	☐	☐
chronic bad breath	☐	☐	blood in stool	☐	☐
sores on lips/tongue	☐	☐	hemorrhoids	☐	☐
history of G.I. disease	☐	☐	List: _____		

Continued on next page.

For Women Only:

	past	current		past	current
irregular periods	☐	☐	breast pain	☐	☐
painful periods	☐	☐	vaginal discharge	☐	☐
bleeding between periods	☐	☐	STDs	☐	☐
period clots	☐	☐	hot flashes	☐	☐
menstrual cramping	☐	☐	night sweating	☐	☐
PMS	☐	☐	bacterial vaginosis	☐	☐
low libido	☐	☐	yeast infections	☐	☐

age of first menses _____ duration of typical period _____

duration of typical cycle _____ date of last PAP _____

# of pregnancies _____ # of live births (+ years) _____

# of miscarriages _____ # of abortions _____

Have you been through menopause? Age? _____

Have you ever taken birth control pills? When and for how long? _____

Other premenstrual & menstrual symptoms (bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.)

_____

_____

_____

For Men Only:

	past	current		past	current
erectile dysfunction/impotence	☐	☐	ejaculatory pain	☐	☐
varicocele	☐	☐	BPH	☐	☐
low libido	☐	☐			

Lifestyle

Current medications/herbs/supplements:

_____

_____

_____

Do you follow any certain diet or way of eating? (vegetarian, gluten-free, paleo, etc.)

_____

_____

_____

Current exercise routine:

_____

_____

_____

Do you use tobacco? If so, how often?

_____

_____

Do you drink alcohol? If so, how many drinks/week?

_____

_____

Are you currently taking any other pain medications including over-the-counter? If yes, list name and amounts per day:

_____

_____

_____

_____

_____

Allergies (medications/foods/chemicals/etc.):

_____

_____

_____

Have you ever had a seizure? If yes, indicate date of last: _____

Please circle any significant illnesses and indicate date:

Cancer	Hepatitis	Diabetes
High blood pressure	Epilepsy	Heart Attack
Stroke	Ulcer Disease	Liver Disease
Colon Polyps	Other _____	

Please list any major surgeries/hospitalizations and approximate dates:

_____

_____

_____

Family Medical History

□ Cancer □ Seizures □ High blood pressure □ Stroke □ Diabetes

□ Heart Attack □ Hepatitis □ Asthma □ Other _____

Please list any other relevant information or issues you would like to discuss:

Appointment, Cancellation and Refund Policy:

Our schedule is coordinated on a "by appointment only" basis. This allows us to run as close to on time as possible, respect your time as an individual, and make your experience in our office stress free, relaxing and enjoyable.

Appointments: Initial: _____

The doctor has provided you with an individual program of care. We highly recommend scheduling your appointments in advance for three reasons:

1. You are more likely to get the appointment times you desire & you don't have to reschedule on every visit. This saves you and our staff time at making your experience efficient and effective.

2. Studies have shown that people who put health on their schedule will more likely keep their appointment and thereby achieve better therapeutic results.

3. Your appointment time is specifically reserved for you to better assist you at achieving your wellness goals.

Cancellation: Initial: _____

If you are scheduled for 1 or more visits per week and you need to change or cancel that visit, please reschedule a "make up" appointment within THREE BUSINESS DAYS to keep to your program of care.

Please respect our time and the time of others by providing us with a 24-hour notice if you must cancel or reschedule your appointment. This allows us enough time to schedule another individual trying to get in for care.

Should you not show for your appointment, cancel or change your appointment with less than a 24-hour notice, you will be billed $65.00 for that time reserved for you.

Payment: Initial: _____

Payment is due when services are rendered on a visit-to-visit basis or a "wellness program" basis. Accepted methods of payment are by cash or credit card (MC or VISA).

Refund Policy – Wellness Programs:

All pre-paid, unused wellness programs are 100% refundable within 72 hours of purchase. After, all refunds will be charged at full price, not at discounted price, for unused sessions only. Unused sessions may be transferred to a spouse, dependent child or parent after they have been established with Chah Acutherapy, LLC. All prepaid programs are good for 365 days from date of purchase. Beyond 365 days of purchase, all unused sessions are forfeited.

I have read and understand the Appointment, Cancellation and Payment Policy of this office. I understand that I will only be billed if I do not follow the cancellation portion of this policy.

Signature _____ Date _____

Print Name _____

Notice of Privacy Policies

This notice describes our policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways; Information we receive, information we receive from other healthcare providers, and information we receive from third party payers.

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations.

You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

This office may use or disclose your Protected Health Information when required by law.

Upon written request, you have the right to access, review or receive copies of your healthcare records. Upon written request, you have the right to receive a list of items this office disclosed about your healthcare information. Upon written request, you have the right to request that this office place additional restrictions on disclosure of your Protected Health Information. Upon written request, you have the right to request that we amend your Protected Health Information. You have a right to receive all notices in writing.

If you have questions, complaints or want more information, please contact us.

You may also send a written complaint to the U.S. Department of Health and Human Services:

DHHS (Office of Civil Rights)

200 Independence Ave S.W. Room 509 F HHH Building

Washington, DC 20201

_____ _____

Signature Date

Thank you for taking the time to fill out these forms. Please let us know if you have any questions or concerns!

Health Information Release Form

In order to assist you in receiving your health information from Chah Acutherapy, LLC please complete this form.

I authorize the persons listed below to have access to any and all of my health information, including drug and alcohol abuse and psychiatric records. Chah Acutherapy is permitted to share any medical information with them, including test results, pathology reports and information disclosed during office visits.

Person(s) authorized to receive any medical information are the following. (Please provide full name and phone numbers).

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

You may notify me or the parties above with appointment reminders, normal-test results and any other information including my health as follows:

□ Message on Answering Machine – Phone Number: _____

□ Message / Texts on Cell Phone –Phone Number: _____

□ Emails

Patient Signature (or Parent/Guardian): _____

Date: _____

Doctor Signature: _____

Date: _____

Consent for Treatment

I hereby request and consent to the performance of Acupuncture treatments and other procedures within the scope of the practice of Acupuncture and Oriental Medicine on me (or on the patient named below, for whom I am legally responsible) by the Acupuncture or Physician named below and/or other licensed Acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the Acupuncturist named below, including those working at Chah Acutherapy, LLC, whether signatories to this form or not.

I understand the modalities of treatment may include, but are not limited to: Acupuncture, manual and/or electrical stimulation of the needles, cupping, moxibustion, and Acupuncture-injection therapy, medical-massage therapy, Chinese herbal medicine, and alternative-nutritional counseling.

I have been informed that Acupuncture is generally a safe method of treatment, but that it may have some side effects, although extremely rare, and risks may include feeling weak, nauseated, faint, infection or bruising at the site of the needle insertion, and worsening of symptoms occasionally, bruising, numbness or tingling near the needle sites that may last a few days, dizziness or fainting. Unusual risks of Acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture. Infection is another possible risk, although extremely rare, as the clinic uses sterile disposable needles and maintains a safe and clean environment. Bruising is a comment side effect of cupping. Burns and/or scarring are a potential risk of moxibustion, cupping and the use of the heat lamps although this is extremely rare.

I understand the herbs may need to be prepared and the teas consumed according to the instructions provided orally and/or in writing. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling on the tongue. I will notify the Acupuncturist who is caring for me if I am or become pregnant. I will immediately notify a member of the clinic staff of any unanticipated or unpleasant effects associated with the consumption of the herbs, injection therapy and/or Homeopathic medicines.

Patient Signature (or Parent/Guardian): _____

Date: _____

Doctor Signature: _____

Date: _____