

Please take time to fill out this questionnaire as complete and accurately as possible. This will help us provide you with the best possible care. If you have anything to add to the questionnaire, please do so in the comments section. All answers will be kept in the strictest confidence.

Name: _____

Social Security Number: _____

Address: _____

Home Phone: _____

Work Phone: _____

Sex/Date of Birth:

State of Birth: _____

Height/Weight: _____

Single ___ or Married ___

Employer Name/Your Occupation:

E-mail: _____

Family Physician Name and Telephone Number:

Emergency Contact Name and Telephone Number:

What is the main reason you are here today? _____

How long ago did this problem begin? _____

How does this problem interfere with your daily activities? _____

Have you been given a diagnosis for this problem by a medical doctor? If so, what?

What kind of treatment have you tried or are presently trying for this problem?

Past Medical History has Included (Please circle and include date):

Cancer _____

Surgeries (type & date) _____

Diabetes _____

Significant Trauma (auto accidents, falls, concussion, etc.)

Hepatitis _____

High Blood Pressure _____

Birth History (prolonged labor, forceps delivery, etc.)

Heart Disease _____

Allergies (drugs, chemicals, food, etc.) _____

Rheumatic Fever _____

Immediate Family Medical History (please include list of diseases)

Thyroid Disease _____

HIV _____

Restricted Diets (what type) _____

Other _____

Medicines Taken Within the Last 2 months (herbs, vitamins, drugs)

Have you had any occupational stresses (chemical, physical, psychological, etc.). If so, what type?

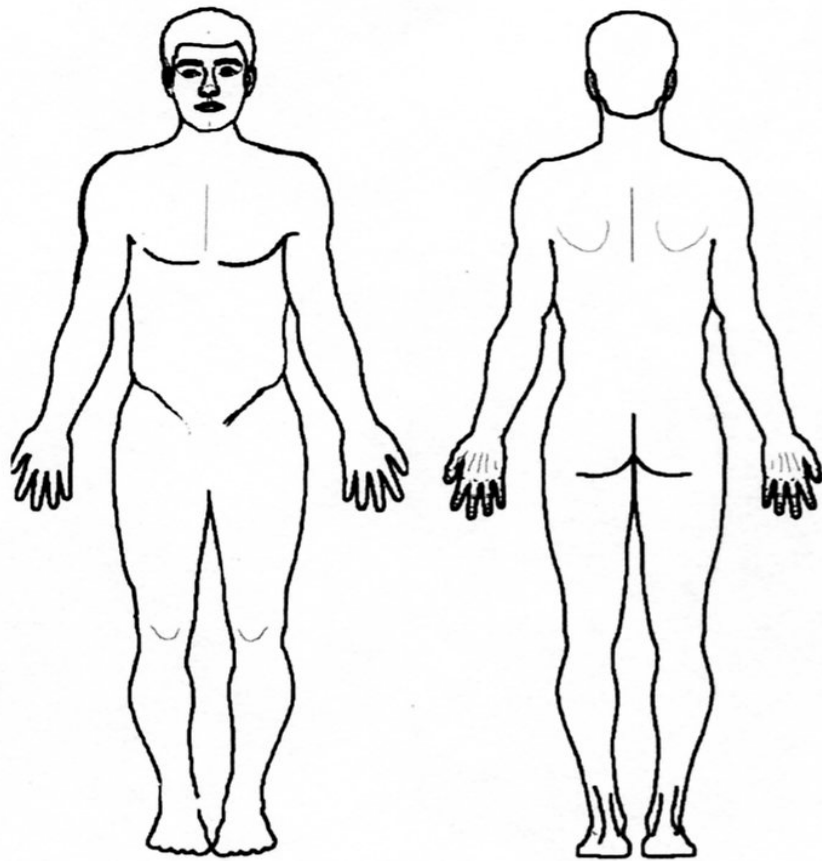
Do you exercise regularly? If so, what type of exercises do you do`?

Please list what you might eat during an average day, to include what type and how many drinks.

Do you smoke/chew tobacco or drink alcoholic beverages? If so, what type and how much do you consume in an average day? _____

Please describe any recreational use of drugs. _____

Please Mark the Areas That You Have Pain Below



MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

Please Check Any of the Following Problems That You May Have Had Within the Last 3 Months

General

- Chills
- Fevers
- Sweating Easily
- Night Sweating
- Local Weakness
- Bleeding or Bruising Easily
- Strange Tastes or Smells
- Strong Thirst for Cold/Hot liquids
- Fatigue
- Energy Drop
(Time of Day _____)
- Fluid Retention
(Where _____)
- Poor Sleep
- Tremors (Shaking)
- Poor Balance
- Cravings
(For What _____)
- Change in Appetite
- Poor Appetite
- Unexplained Weight Gain/Loss

Skin and Hair

- Rashes
- Itching
- Change in Hair/Skin
- Ulcerations
- Eczema
- Oozing Skin Lesions
- Hives
- Pimples
- Recent Moles
- Hair Loss
- Dandruff

Head, Eyes, Ears, Nose and Throat

- Dizziness
- Migraines
(When _____ where _____)
- Face Pain
- Use Glasses
- Poor Vision
- Night Blindness
- Blurry Vision
- Color Blindness
- Blind Fields
- See Spots in Front of Eyes
- Eye Pain
- Eye Strain
- Cataracts
- Dry Eyes
- Too Many Tears
- Eye Discharge
- Poor Hearing
- Ringing in the Ears
- Earaches
- Ear Discharge
- Nose Bleeds
- Sinus Congestion
- Nose Discharge
- Teeth Grinding
- Teeth Problems
- Jaw Clicking
- Concussions
- Repeated Sore Throats
- Hoarse Voice

Heart Related

- High Blood Pressure
- Low Blood Pressure
- Chest Pain
- Heart Palpitations (Pounding sensation)
- Cold Hands/Feet
- Swollen Hands/Feet
- Blood Clots
- Fainting
- Breathing Difficulty

Stomach and Bowels

- Bad Breath
- Nausea
- Vomiting
- Heartburn
- Burping
- Indigestion
- Diarrhea
- Constipation
- Always use Laxatives
- Bloody Stools
- Black Stools
- Stomach Pain
- Gas
- Rectal Pain
- Hemorrhoids

Lungs and Breathing

- Coughing
- Asthma/Wheezing
- Pain When Taking a Deep Breath
- Hard to Breathe When Lying Down
- Coughing Phlegm
(What Color _____)
- Coughing Blood
- Pneumonia
- Bronchitis

Pregnancy and Women's Issues

- N

- Number of Births_____
- Number of Premature Births_____
- Number of Miscarriages_____
- Number of Abortions_____
- Age at First Menses_____
- Period Between Menses (Days)_____
- Duration of Menses (Days)_____
- Date of Last Menses (___/___/___)
- Heavy Periods
- Light Periods
- Painful Periods
- Irregular Periods
- Changes in Body/Mood Prior to or During Menses
- Clots
- Menopause (Age____, Year_____)
- Vaginal Discharge
- Bleeding after sex
- Vaginal Sores
- Date of Last PAP Smear___/___/___
- Breast lumps
- Nipple Discharge

Nervous System/Emotional

- Seizures
- Areas of Numbness
- Weakness
- Sleep Disorder
- Concussion
- Bad Temper
- Loss of Control/Violent Actions
- Vertigo (Loss of Balance)
- Lack of Coordination
- Depression
- Get Stressed Easily
- Poor Memory
- Anxiety
- Substance Abuse
- Treated for Emotional Difficulties
- Considered or Attempted suicide or Harmed
- Yourself

Pain

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

Any Other Comments That You Would Like To Make



Sunny Tan, LAc. LMP ,J.A.C

MD. In China

727 228TH ST SE. BOTHELL.WA.98021

Therapies Are Natural

(425)806-4861 CELL:206-940-8698

Information For Patients

Practitioners in this Clinic: A licensed and certified acupuncturist will provide your treatment. The practitioner in this clinic received an MD in China in 1983, an OMD in China in 1978, an M.Ac. in 2002 and is a licensed acupuncturist in Washington State. Additionally, she is a Diplomat of Acupuncture with the National Certification Commission for Acupuncture and Oriental Medicine.

Nature of Treatment: Your treatment may include acupuncture, moxibustion (the burning of herbs over or on a specific acupuncture points or locations), cupping (the use of cups to obtain suction around specific acupuncture points or locations), electric magnetic stimulation, acupressure (pressing on specific acupuncture points or location), dermal friction ,rubbing (Gua Sha), infra-red (head lamps), sonopuncture (sound stimulation), laserpuncture, point injection therapy (injecting herbs into specific acupuncture points or locations), Asian and/or domestic herbs, therapeutic exercises and dietary counseling based on the theory of Asian medicine.

Purpose of Treatment: The purpose of treatment is to provide you a measure of relief from the main reason why you have visited this clinic. Acupuncture and Oriental Medicine is a health care service that is based upon the Asian system of medical theory. Diagnosis and treatment that is based upon this theory is used to promote your health and to treat a wide variety of disorders.

Benefit of Treatment: Acupuncture and Oriental Medicine procedures have been used effectively to treat disease for several thousand years. The World Health Organization lists 40 conditions that may effectively be treated by Asian medical methods. These include muscular-skeletal injuries, digestive disorders, respiratory diseases, women’s health issues, chronic pains, etc. *While we are confident that our treatments will be of benefit to you, we cannot guarantee the outcome of any course of treatment.*

Risks of Treatment: Treatments have been shown to be very safe and effective. There are some uncommon, but potential, risks which may include, but are not limited to:

- discomfort during and after the insertion of a needle
- “needle sickness” (dizziness, fainting, nausea)
- localized, minor bruising or swelling
- minor burns with the use of moxa (the practitioner will remain in the room during use)
- gastro-intestinal upset with the use of herbs (if this occurs, immediately consult with the practitioner to change your formula)
- possible temporary aggravation of your symptoms that existed to treatment
- broken needles (rare with the use of disposable needles used in our clinic)
- infection (rare with the use of disposable needles used in our clinics)

Please immediately tell the practitioner if you experience any adverse effects

Special Situations: Some herbal formulas and acupuncture points are not to be used during pregnancy or in certain cases of elevated blood pressure. Please tell the practitioner if you are or might suspect that you are pregnant or have elevated blood pressure. In addition, if you have a severe bleeding disorder or are wearing a pacemaker or any other electronic medical device, please tell the practitioner.

Use of Disposable Needles: In order to reduce the possibility of infection from acupuncture, all needles used in this clinic are pre-sterilized, one-time-use only needles made of surgical stainless steel and sealed in sterile individualized packages. After the needle is used one time, it is disposed of as medical waste, never to be reused again. All practitioners are certified in Clean Needle Technique and Universal Precautions.

Unforeseen Risks: Unfortunately, although our practitioners are not able to anticipate all risks or unexplained complications that may arise during a treatment, we will exercise judgement based upon your best interests.

Confidentiality of Medical Records: The practitioner and administrative staff may review your medical records and reports for use within the clinic to determine treatment methods and to update your records. Additionally, upon your written consent, your medical record may be provided to an insurance carrier, legal authority or another health care provider.

Requirements of Washington State Law: Washington State Law does not permit licensed acupuncturists to treat certain disorders without the consultation of a physician (MD). These conditions are:

- Cardiac conditions including uncontrolled hypertension
- Acute abdominal symptoms
- Acute undiagnosed neurological changes
- Unexplained weight loss or gain in excess of 15% of body weight within a 3 month period
- Suspected systemic infection
- Any serious undiagnosed hemorrhagic disorder
- Acute undiagnosed respiratory distress

Consent: I, _____, request and consent to treatment using Oriental Medicine procedures. I understand that I am free to withdraw my consent and stop treatment at any time. I understand that my signature on this form signifies that I have read and understood the information contained on this form and that I release the Acupuncture & Disability Research Center and their licensed acupuncturists from any and all liability that may be incurred in connection with the treatment procedures to be performed, except for failure to perform those procedures with appropriate medical care.

Patient Name: _____ Signature: _____

Witness: _____ Date: _____

Personal health information

PERSONAL DATA

Name _____ Date: _____ referred by: _____

Address: _____

Phone-home: ()- -

City/State Zip: _____

Phone-work: ()- -

Email: _____

Single _____ or Married _____

Sex/Birthday: _____

Occupation/Employer: _____

Primary Health Care Provider: _____

phone: _____

Permission to consult with primary provider? please initial if yes. Yes _____ No

Emergency contact: _____ Phone _____

MESSAGE HISTORY/TREATMENT INFORMA-

Have you ever received a professional massage? Yes No If yes, frequency _____ date of last message _____

What results do you want from your massage sessions _____

Prioritize the areas of your body that you would prefer to be massaged. _____

Please check the areas of your body that you give permission to receive massage:

back legs buttocks arms abdomen chest chest neck head face other _____

are you currently seen a medical practitioner? Please explain if yes. Yes No _____

Are you currently seeing a psychotherapist or are you attending regular support group meetings? Please explain if yes. Yes No _____

List stress reduction and exercise activities. Include frequency. _____

List current medications, including aspirin, ibuprofen, etc. _____

PREVIOUS HISTORY (Include year and treatment received)

Surgeries: _____

Accidents: _____

HEALTH HISTORY

MUSCULO-SKELETAL

___ bone or joint disease _____
___ tendonitis _____
___ bursitis _____
___ broken/fractured bones _____
___ arthritis _____
___ sprains/strains _____
___ low back, hip, leg pain _____
___ neck, shoulder, arm pain _____
___ headaches/head injuries _____
___ spasms/cramps _____
___ jaw pain/TMJ _____
___ lupus _____
___ other _____

CIRCULATORY

___ heart condition _____
___ varicose veins _____
___ blood clots _____
___ high blood pressure _____
___ low blood pressure _____
___ lymph edema _____
___ breathing difficulty _____
___ sinus problems _____
___ allergies _____
___ other _____

INFECTIOUS DISEASE

___ disease name(s): _____

SKIN

___ allergies _____
___ rashes _____
___ athletes foot _____
___ warts _____
___ other _____

DIGESTIVE

___ constipation _____
___ gas/bloating _____
___ diverticulitis _____
___ irritable bowel syndrome _____
___ other _____

NERVOUS SYSTEM

___ herpes/shingles _____
___ numbness/tingling _____
___ chronic pain _____
___ fatigue _____
___ sleep disorders _____
___ other _____

REPRODUCTIVE

___ pregnant? Stage _____
___ PMS _____
___ other _____

OTHER

___ cancer/tumors _____
___ diabetes _____
___ eating disorders _____
___ depression _____
___ drug/alcohol addiction _____
___ nicotine/caffeine addiction _____

It is my choice to receive massage therapy. I realize that the treatment is being given for the well- being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well being is being compromised.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitution for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

SIGNATURE: _____ DATE: _____

INITIAL INJURY INFORMATION

Name: _____ Date of Onset: _____

Description of Onset: _____

Primary Symptoms:

Rate symptom intensity "mild", "moderate", "severe"

List all symptoms immediately post injury: _____

List all other associated symptoms prior to today: _____

What physical duties are required for your job? _____

What regular activities of daily living are affected by this injury? _____

List all adjunctive therapies received for this injury: _____

Insurance &/or attorney information: _____

To whom should treatment billing be sent? _____

INSURANCE INTAKE FORM

Sunny (yanmin) Tan, LAc, LMP, 727 228th ST SE, Bothell, WA, 98021

PATIENT Name _____ Address _____ _____ Employer _____	Date of Birth _____ Phone (Home) _____ Phone (Work) _____ Single ____ Married ____ Male ____ Female _____
PRIMARY PLAN INFORMATION Plan Name _____ Address _____ _____	ID# OR SSN : _____ Group# _____ Phone# _____
RELATIONSHIP TO INSURED Self ____ Child ____ Spouse ____ Other _____	INSURED INFORMATION, IF OTHER THAN YOURSELF Name _____ Address _____ _____
SECONDARY INSURANCE INFORMATION Plan Name _____ Address _____ _____ _____ Phone# _____	Date of Birth _____ ID# or SSN: _____ Adjuster's Name _____ Date of Injury _____ Name of Insured _____

I agree to the release of any medical information my health insurance may need in order to process payment. I assign some benefits to be paid to the above named provider. In the event that my insurance coverage expires or denies payment.

I understand that I am personally responsible for all fees incurred unless other arrangements have been made.

Signature _____ Date _____

INSURANCE COVERAGE

INSURANCE COMPANY: TELEPHONE:
 LAST NAME: FIRST NAME:
 DOB: MEMBER ID: GROUP#:
 M OR F MARRIED OR SINGLE
 INSURER'S LAST NAME: FIRST NAME: DOB RELATION:

	ACUPUNCTURE	MASSAGE
WHEN DOES THIS INSURANCE POLICY START (MM/DD/YY)?		
IS ANY AUTHORIZATION REQUIRED? WHAT IS PHONE #?	<input type="checkbox"/>	<input type="checkbox"/>
IS REFERRAL FROM PCP REQUIRED?	<input type="checkbox"/>	<input type="checkbox"/>
IS DR'S PRESCRIPTION REQUIRED	<input type="checkbox"/>	<input type="checkbox"/>
HOW MANY VISITS PER YEAR ALLOWED	IN \$ <input type="checkbox"/>	In \$ <input type="checkbox"/> COMBINE <input type="checkbox"/>
IS THERE DEDUCTIBLE TO BE MET \$	\$	\$
HOW MUCH DEDUCTIBLE HAS APPLIED \$		
IS THERE A PATIENT CO-PAY %	\$	\$
IS THERE A PATIENT CO-INSURANCE \$	%	%
WHAT IS THE MAXIMUM BENEFIT ALLOWED/YEAR	IN \$ <input type="checkbox"/>	In \$ <input type="checkbox"/> COMBINE <input type="checkbox"/>
WHAT IS CLAIM ADDRESS		
CLAIMS ADDRESS		
OUT OF POCKET \$/YERA	IN \$ <input type="checkbox"/>	IN \$ <input type="checkbox"/>

Diagnosis Code: 723.1 724.2

Procedure Code (CPT): ACUPUNCTURE: 97813, 97814, 97810, and 97811.

MASSAGE: 97124, 97140

INSURANCE PHONE CALLED #:
REFERENCE#

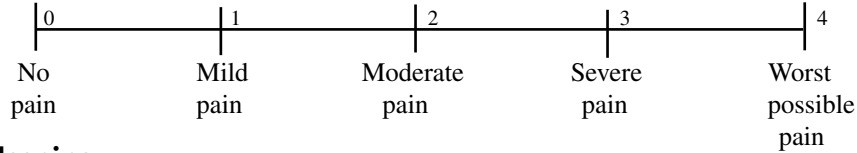
NAME OF PERSON:
DATE CALLED:

Functional Rating Index

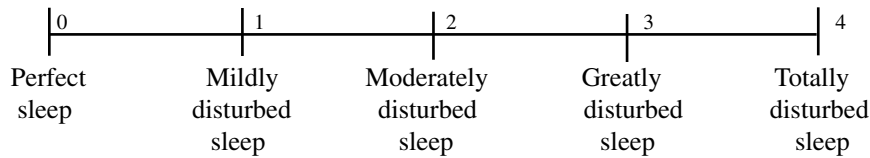
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

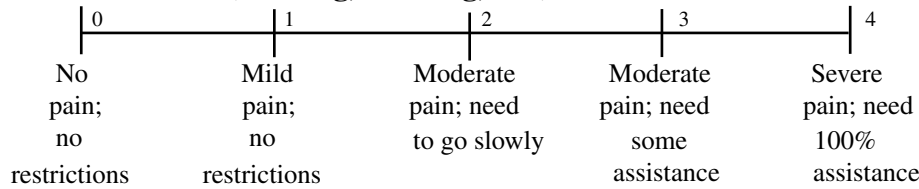
1. Pain Intensity



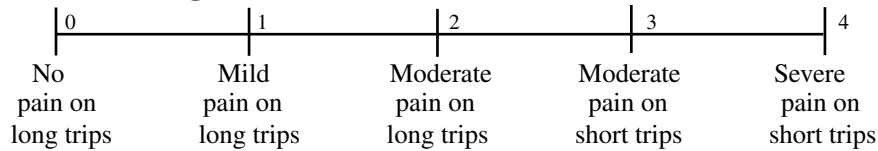
2. Sleeping



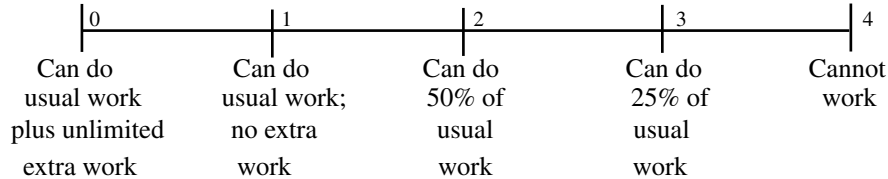
3. Personal Care (washing, dressing, etc.)



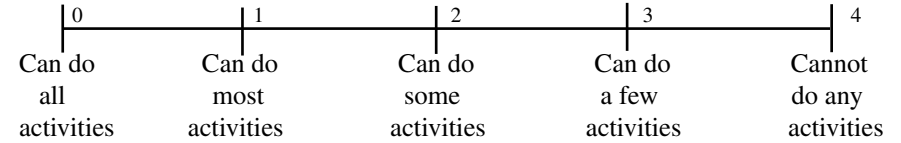
4. Travel (driving, etc.)



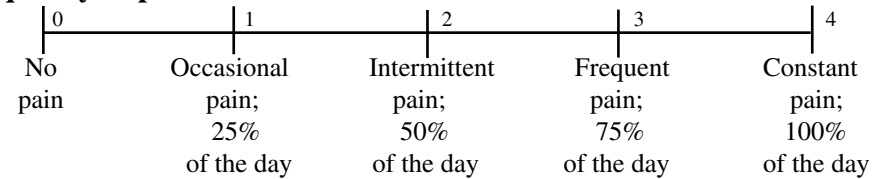
5. Work



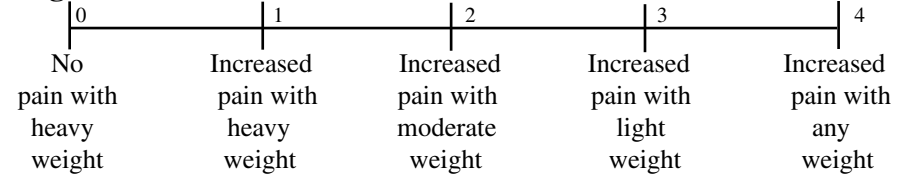
6. Recreation



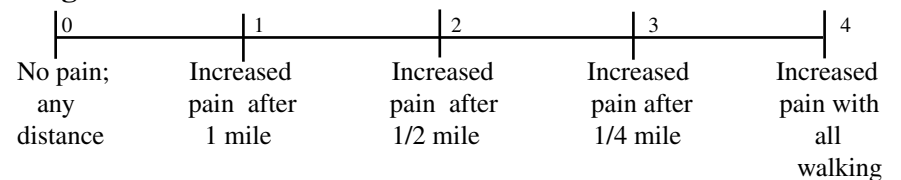
7. Frequency of pain



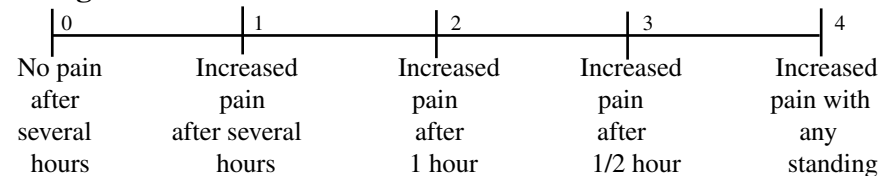
8. Lifting



9. Walking



10. Standing



Name _____ ID#/SS# _____ Plan ID _____ Total Score _____

PRINTED

Signature

Date