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:_____

Adress:_____

_____

Sex/Date of Birth:

_____

Height/Weight:_____

E-mail:_____

Family Physician Name and Telephone Number:

_____

Social Security Number:_____

Home Phone:_____

Work Phone:_____

State of Birth:_____

Single____ or Married_____

Employer Name/Your Occupation:

_____

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_____
Diabetes_____
Hepatitis_____
High Blood Pressure_____
Heart Disease_____
Rheumatic Fever_____
Thyroid Disease_____
HIV_____
Other_____

Surgeries (type & date)_____
Significant Trauma (auto accidents, falls, concussion, ets.)

_____
Birth History (prolonged labor, forcepts delivery, etc.)

_____
Allergies (drugs, chemicals, food, etc.)_____
Immediate Family Medical History (please include list of diseases)

_____
Restricted Diets (what type)_____
Medicines Taken Within the Last 2 months (herbs, vitamins, drugs)

_____

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

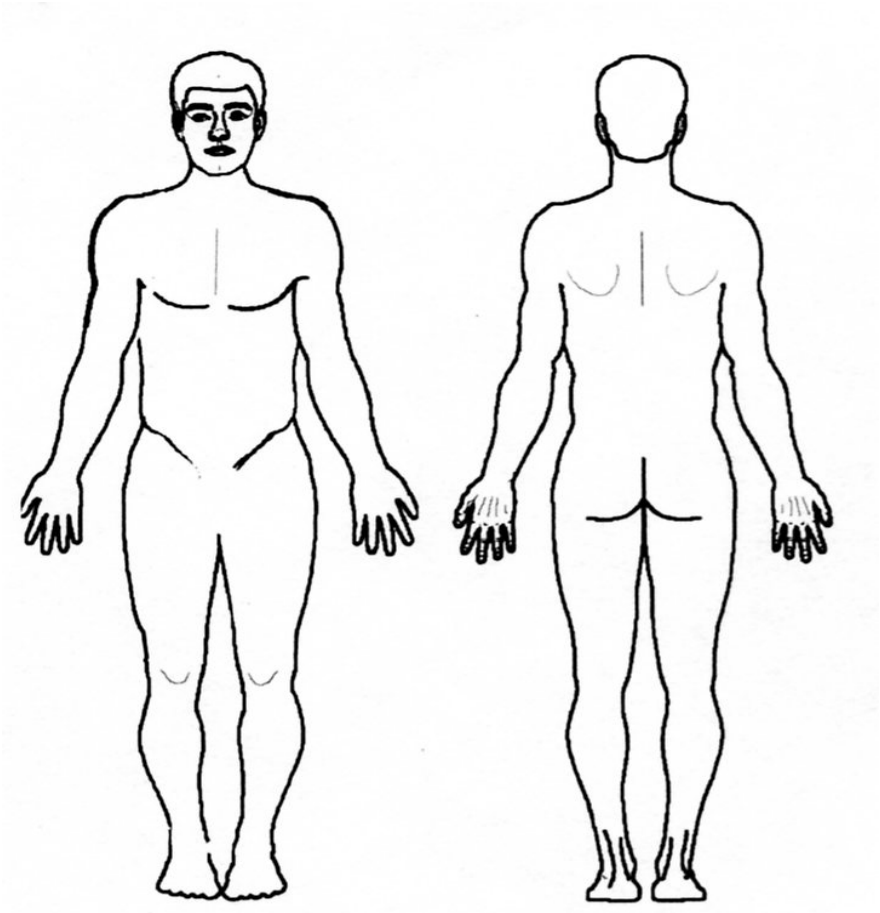
Do you exercise regularly? If so, what type of exercises do you do`?

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



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 of 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 Breath 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 ,l.A.C MD. In China 727 228TH ST SE. BOTHELL.WA.98021

(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 clnis)

Please immediately tell the practitioner if you experience <u>any</u> adverse effects

Special Situations: Some herbal formulas and acupuncture points are not to 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 a 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 package. 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.

Unforseen Risks: Unfortunately, although our practitioners are not able to anticipate all risks or unexplained complication 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 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 an dall 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_____

MASSAGE HISTORY/TREATMENT INFORMA-

Have you ever received a professional massage? ☐ Yes ☐ No If yes, frequency_____date of last massage_____

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

____ desease 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 _____

PRIMARY PLAN INFORMATION

Plan Name_____

Address _____

_____

RELATIONSHIP TO INSURED

Self _____ Child _____

Spouse ___ Other _____

SECONDARY INSURANCE INFORMATION

Plan Name_____

Address _____

_____

_____

Phone#_____

Date of Birth _____

Phone (Home)_____

Phone (Work)_____

Single ____Married _____

Male _____ Female _____

ID# OR SSN :_____

Group#_____

Phone#_____

INSURED INFORMATION, IF OTHER THAN YOURSELF

Name_____

Address_____

_____

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 _____

INSURACE COVERAGE

INSURANCE COMPANY: TELEPHONE:
LAST NAME: FIRST NAME:
DOB: MEMBER ID: GROUP#:
M☐ OR F ☐ MARRIE☐ OR SINGLE☐
INSURENDER '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 #?	☐	☐
IS REFERRAL FROM PCP REQUIRED?	☐	☐
IS DR'S PRESCRIPTION REQUIRED	☐	☐
HOW MANY VISITS PER YEAR ALLOWED	**IN $☐**	**In $☐COMBINE☐**
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 $☐**	**In $☐COMBINE☐**
WHAT IS CLAIM ADDRESS		
CLAIMS ADDRESS		
OUT OF POCKET $/YERA	**IN $☐**	**IN $☐**

Diagnosis Code: 723.1 724.2
Procedure Code (CPT): ACUPUNCTURE: 97813, 97814, 97810, and 97811.
MASSAGE: 97124, 97140
ISURACE PHONE CALLED #: NAME OF PERSON:
REFRENCE# 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

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

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

PRINTED

_____

Signature

_____

Date