ACUPUNCTURE & CHINESE MEDICINE ACADEMY, INC.
XIULING MA, PHD, OMD, MS, L.AC.

291 South La Cienega Boulevard, Suite 211
Beverly Hills, CA 90211
Tel: (310) 652-1880 Website: acupunctureworld.org

Patient Confidential Information

Name: ____
First Middle Last

Address: ____
Street City State Zip

Home Phone: ______________________ Business Phone: ______________________

Cellular Phone: ______________________ Email Address: ______________________

Fax Number: ______________________ Insurance: ______________________

Age ____ Date of Birth _____/_____/_____ Gender: M F Marital Status: S M D W

Place of Birth: ______________________ Social Security No.: ______________________

Occupation: ______________________ Employer: ______________________

In Case of Emergency, Call: ______________________________________
Name Relation

Address: ____
Street City State Zip

Phone Number: ______________________

<u>PAYMENT IS DUE AT THE TIME OF SERVICE</u>

Your appointments are valuable to us. To ensure that all our patients receive the same treatment opportunities, it is important that you keep your scheduled appointment. If a cancellation is absolutely necessary, our office requests that it be made **within a minimum of 24 hours** notice, or you will be charged for the visit at our standard fee. Thank you for your understanding.
I have read and understand the above:

Patient/Guardian Signature: ______________________________ Date: ____________

Please Print Your Name: ______________________________

What is your chief complaint? ____

____

When did this condition begin? ____

What treatment have you already received for this condition? ____________________

____

____

Please list all previous operations and the approximate date of the procedure: ____________

____

____

Fractures and other serious injuries: ____

____

Allergies: ____

____

____

Medications (please include the dose and how often you take it): __________________

____

Family History: (list blood relatives that have, or had, any of the following conditions)

			Relationship to you:
Stroke	Yes	No	____________________
Cancer	Yes	No	____________________
Heart Disease	Yes	No	____________________
Tuberculosis	Yes	No	____________________
Bleeding Tendency	Yes	No	____________________
Diabetes	Yes	No	____________________
High Blood Pressure	Yes	No	____________________
Kidney Disease	Yes	No	____________________

Referred by Relationship and Phone

SYMPTOMS **Check the box next to the symptoms you currently have or have had in the past year.**

GENERAL

- ❑ Chills
- ❑ Depression
- ❑ Dizziness
- ❑ Fainting
- ❑ Fever
- ❑ Forgetfulness
- ❑ Headache
- ❑ Loss of sleep
- ❑ Loss of weight
- ❑ Nervousness
- ❑ Numbness
- ❑ Sweating

MUSCLE, JOINT, BONE

Pain, weakness, numbness in:

- ❑ Back
- ❑ Neck
- ❑ Shoulders
- ❑ Arms
- ❑ Hands
- ❑ Hips
- ❑ Legs
- ❑ Feet

GENITO-URINARY

- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful urination

GASTROINTESTINAL

- ❑ Poor appetite
- ❑ Bloating
- ❑ Bowel changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Excessive hunger
- ❑ Excessive thirst
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Nausea
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Vomiting blood

CARDIOVASCULAR

- ❑ Chest pain
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling of ankles
- ❑ Varicose veins

EYE, EAR, NOSE, THROAT

- ❑ Bleeding gums
- ❑ Blurry vision
- ❑ Crossed eyes
- ❑ Difficulty swallowing
- ❑ Double vision
- ❑ Earache
- ❑ Ear discharge
- ❑ Hay fever
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Persistent cough
- ❑ Ringing in ears
- ❑ Sinus problems
- ❑ Vision – Flashes
- ❑ Vision – Halos

SKIN

- ❑ Bruise easily
- ❑ Hives
- ❑ Itching
- ❑ Change in mole(s)
- ❑ Rash
- ❑ Scars
- ❑ Sores that do not heal

MEN ONLY

- ❑ Erection difficulties
- ❑ Lump in breast
- ❑ Lump in testicles
- ❑ Penis discharge
- ❑ Prostate problems
- ❑ Sore on penis
- ❑ Other: ____________________

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WOMEN ONLY

- ❑ Abnormal Pap Smear
- ❑ Bleeding between periods
- ❑ Breast lump(s)
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ Nipple discharge
- ❑ Painful intercourse
- ❑ Vaginal discharge
- ❑ Vaginal infections
- ❑ Other:_________ __________

____

Age of first period: ________

Date of last period ____________

Date: last PAP smear ___________

Have you had a mammogram?

____

Are you now pregnant? __________

Number of children: ____________

CONDITIONS Check the box next to the symptoms you currently have or have had in the past.

- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer or Tumor(s)
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Congenital Abnormalities
- ❑ Diabetes
- ❑ Epstein Barr Virus
- ❑ Emphysema
- ❑ Epilepsy or Convulsions
- ❑ Genital Disorders
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ High Cholesterol
- ❑ HIV Positive
- ❑ Jaundice
- ❑ Kidney or Bladder problems
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraine Headaches
- ❑ Miscarriage No. _____
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pancreatitis
- ❑ Pneumonia
- ❑ Polio
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Skin Diseases
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Surgical Implants ________

____

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- ❑ Thyroid – Hyperthyroidism
- ❑ Thyroid – Hypothyroidism
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Other: ______________

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HEALTH HABITS Check which substances you use & describe how often you use them.

	Caffeine	
	Tobacco	
	Street Drugs	
	Alcohol	
	Other	

PREGNANCY HISTORY

Year of Birth	Gender (M / F)	Complications, if any

Dr. Xiuling Ma
Acupuncture & Chinese Medicine Academy, Inc
291 South La Cienega Blvd. Suite #211, Beverly Hills, CA 90211

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

What is HIPAA and what are its benefits?

The Health Insurance Portability and Accountability Act (HIPAA) went into effect on July 1, 1997. It protects an insured person's insurability. If a person has been insured for the past 12 months, a new insurance company cannot refuse to cover the person and cannot impose pre-existing conditions or a waiting period before providing coverage.

Our office respects your right to privacy. Information regarding the reason you sought therapy with us is strictly confidential and is used to communicate with your doctor, case worker, and claims for payment from your insurer and the Dept. of Labor & Industrial Relations (for Workers' Comp. claims) or for pre-authorization. Should any other official party request information about you, we would need to see your signed authorization to release information. All other uses of the protected health information will be made only with your authorization and you have the right revoke such authorization at any time. If a claim is unpaid due to the unavailability of the requested information, then you will be responsible for payment to us.

Evaluation reports, treatment plans, copy of prescriptions for therapy and progress notes are generally mailed to the insurer (case worker) to carry out treatment and receive payment for services.

In settlement cases, your attorney can request copies of your file with a written authorization from you. The other party's attorney will generally subpoena your records. A **subpoena** is a legal demand with which we must comply.

All therapies are on an appointment basis.

If you have questions regarding other alternatives, we can give you general information. Your primary care physician will determine what program for you to follow.

Patient Rights Notice of Privacy Policy.

• A patient/client may request restrictions on certain uses and disclosures of the protected information.
• You have the right to receive confidential communication of protected health information.
• You have the right to inspect and request a copy of protected health information & medical records.
• You have the right to amend protected information (there is an appeals process).
• You have the right to an accounting of disclosures of protected health information.

We reserve the right to change our privacy policy in accordance with HIPAA, and would send such notice to your last known address if your case is involved. Healthcare facilities must be in compliance with HIPAA following April 14, 2003, except in emergency treatment situations.

I have read and understood my rights regarding privacy of information and under which conditions this information is shared with others so that I may receive a therapy and claims be made on my behalf (only for insurance purposes).

I acknowledge that I have received the "Patient's Rights" and I will _____, will not _____ take a copy with me. ______ Initials

Signature____ Date___________________

Print Name____

A copy of your rights as our client/patient is available for you and clipped to this form. Please keep that copy. HIPAA Chart.

Patient Information and Informed Consent

Information about Chinese Medicine and Acupuncture

Please carefully read each section below, ask any questions, and initial each section to indicate your understanding of the information:

______ **Acupuncture** is a healing art that involves the stimulation of specific points on the body. It has the intended effect of normalizing body functions, modifying the perception of pain, and treating certain diseases or dysfunctions of the body. The stimulation may be produced by needles, heat, digital pressure, electric currents, or other means, but most frequently by needling. Location and depth of needle insertion is determined by the nature of the problem. Acupuncture is considered a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that lasts a few days.

______ Insertion of acupuncture needles may be accompanied by a brief painful sensation, and there is a slight possibility of minor swelling, bleeding, discoloration of the skin, hematoma (bruise) at the site of needling, or fainting. Momentary euphoria or lightheadedness may occur after treatment. Some very rare risks of acupuncture include fainting, spontaneous abortion, pneumothorax (a partially or fully-collapsed lung due to air in the chest cavity), and infection.

______ Contraindications (symptoms or conditions that make a particular treatment inadvisable) for acupuncture treatment and certain herbs may include a history of bleeding disorder or current anticoagulation therapy, an implanted pacemaker or prosthetic heart valve, use of certain medications, and/or pregnancy. It is important that you notify your practitioner if any of these apply to you.

______ **Moxibustion** is heat supplied, either directly or indirectly, by burning the herb *Folium Artemesiae Vulgaris* over a single acupuncture point or group of points. The area being treated may remain red and warm for several hours after treatment. In rare instances, a minor burn may occur at the site of moxibustion.

______ **Cupping** is the application of round vacuum cups over a large muscular area, such as the back, to enhance blood circulation to the designated area. Cupping may produce a deep redness, discoloration, and on rare occasions, a minor blister which may persist for up to a week. These marks are not indications of complications or injury.

______ **Acupressure/Tui Na Massage** is used to modify or prevent the perception of pain and to normalize the body's physiologic functions. Possible side effects of this treatment include, but are not limited to, bruising, muscle soreness, and the possible aggravation of symptoms existing prior to treatment.

______ **Herbs and/or Nutritional Supplements** from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction, to modify or prevent pain perception, and/or to normalize the body's physiologic functions. Herbs are used to facilitate the body's own restorative process. The herbs are typically taken in tea form or mixing powdered granules.

______ Herbs are considered safe in the practice of TCM, although some substances may be toxic in large doses. Some dietary supplements are inappropriate during pregnancy, may interact with medications or other supplements, may have side effects of their own, or may contain potentially harmful ingredients not listed on the label. Most supplements have not been tested in pregnant women, nursing mothers, or children. Potential risks include but are not limited to: allergic reactions, nausea, gas, stomachache, vomiting, headache, diarrhea, rash, hives, and tingling of the tongue. Some possible side effects of applying topical creams, liniments, ointments and plasters are rashes, hives and tingling of the skin.

______ **Gua sha** means "scraping sha-bruises" and involves using a scraping tool intended to result in minor skin bruising. Some patients experience temporary indentation of their skin after gua sha treatment, and in some instances minor bleeding can occur. If any bleeding occurs, there is an associated risk of infection.

______ **Infrared and TDP (Teding Diancibo Pu)** lamp therapy consists of warming the skin with a heat source mounted to an adjustable arm and positioned above the body. If the heat source comes into close proximity with or contacts the skin, there is the risk of a burn.

Consent for Traditional Chinese Medicine and Acupuncture Treatment

I have provided my full medical history and description of my complaints and health status, which is complete and accurate to the best of my knowledge. I understand the importance of communicating with all of my health care providers regarding my health status. I do not have an implanted pacemaker, defibrillator, or prosthetic heart valve. I do not take steroids or anticoagulants.

I currently take the following medications:

____

For female patients: I am not pregnant, and my last normal menstrual period began on: ___________________________

The diagnosis given to me conforms to the principles of TCM, and in no way purports to replace allopathic (Western) medical evaluation, diagnosis, or treatment. No guarantee has been made concerning the use and effects of TCM. I understand that, in some cases, symptoms may relapse or intensify temporarily during the course of treatment before relief is sustained.

I am not required to take recommended herbs or nutritional supplements, but if I do decide to take these substances, I must follow the directions for administration and dosage. I will immediately notify my practitioner of any unanticipated or unpleasant effects associated with herbs or nutritional supplements.

I understand that it is not possible to anticipate and explain all risks and complications. I understand and agree that practitioner will exercise judgment during the course of treatment which they feel at the time, based on the facts known to them, is in the best interest of me as a patient.

I hereby state that I have read and understand this form, that I have been given an opportunity to ask questions, and that all questions have been answered in a satisfactory manner. I wish to proceed with TCM treatment. I understand that I am free to withdraw my consent to treatment, and/or stop treatment at any time.

____

Patient Name

____

Signature of Patient or person authorized to consent on behalf of the patient Date