Angela Kung Acupuncture and Wellness Center, Inc.

Patient Contact Information

How did you hear about us?

Yelp Google Facebook Instagram

Friend/Family Name: _____

Name: _____ Date of Birth: _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: _____

Cell: _____

Email: _____

Insurance Information (must be PPO)

Name of Insurance: _____

Patient Name (as it appears on your insurance card): _____

ID#: _____ Group# _____

In Case of Emergency, please call:

Name: _____

Relationship: _____

Phone: _____

****All patient information is kept strictly confidential****

Today's Date: _____

Patient Health History Information

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Full name: _____ Age: _____ Gender: M F Marital status: S M D W

1. Please list all health complaints in order of importance:

1._____ 4._____

2._____ 5._____

3._____ 6._____

2. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

3. Please list any medications and supplements (including vitamins) you are currently taking:

Prescriptions:_____

Over-the-counter: _____

Supplements:_____

4. Do you have any reason to believe you may be pregnant? Y N If so, how far along are you? _____

5. Do you have any infectious diseases? Y N If yes, please identify: _____

6. Height: _____ft _____in Current Weight: _____lbs Past Maximum: _____lbs When? _____

7. **Blood Pressure:** What is your most recent reading? _____/_____ When was this reading taken? _____

8. **Family History:**

CHECK THOSE APPLICABLE:	Father	Mother	_____ (Sibling)	_____ (Sibling)	_____ (Sibling)	Spouse	Child	Child
Age (if living)								
In Good Health								
Cancer								
Diabetes								
Heart Disease								
High Blood Pressure								
Stroke								
Mental Illness								
Asthma/Hay Fever/Hives								
Kidney Disease								
Age (at Death)								
Cause of Death								

9. **Hospitalizations and Surgeries:**

Date and Reason: _____

Date and Reason: _____

10. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Date and Reason: _____

Date and Reason: _____

Have you had any surgical removals?

Ovaries Uterus Gallbladder Thyroid

Lifestyle:

a. Do you typically eat at least three meals per day? Y N If not, how many? _____

b. Do you occasionally go on a crash diet? Y N

c. Exercise routine: _____

d. Spiritual practice: _____

f. Level of education completed: High School Bachelors Masters Doctorate Other

g. Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y/N Why/Why not? _____

h. Nicotine/Alcohol/Caffeine Use: _____

i. Have you experienced any major traumas? Y N Explain: _____

_____

j. Do you drink juice, milk, soda, or other drinks besides water when thirsty? Y N

k. How many glasses of water do you drink per day? _____

l. Television habits: _____ Reading habits: _____

m. Interests and hobbies: _____

n. Are you on blood thinners? Y N Do you bruise easily? Y N

Please **check** all that apply

11. **Emotional:**

- ☐ Anxiety
- ☐ Depression
- ☐ Mood Swings
- ☐ PTSD
- ☐ Panic attacks

12. **Energy and Immunity:**

- ☐ Fatigue
- ☐ Slow Wound Healing
- ☐ Chronic Infections
- ☐ Chronic Fatigue Syndrome

13. **Head, Eye, Ear, Nose, and Throat:**

- ☐ Impaired Vision
- ☐ Eye Pain
- ☐ Strain Glaucoma
- ☐ Glasses/Contacts
- ☐ Tearing/Dryness
- ☐ Nose Bleeds
- ☐ Hay Fever
- ☐ Impaired Hearing
- ☐ Ringing/Tinnitus
- ☐ Earaches
- ☐ Headaches
- ☐ Sinus Problems
- ☐ Frequent Sore Throats
- ☐ Teeth Grinding
- ☐ TMJ/Jaw Problems

14. **Respiratory:**

- ☐ Pneumonia
- ☐ Frequent Common Colds
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Persistent Cough
- ☐ Sinus Problems
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Shortness of Breath
- ☐ Other Respiratory Problems: _____

15. **Cardiovascular:**

- ☐ Heart Disease Chest
- ☐ Pain Swelling of Ankles
- ☐ High Blood Pressure
- ☐ Palpitations/Fluttering
- ☐ Stroke
- ☐ Heart Murmurs
- ☐ Varicose Veins

16. **Gastrointestinal:**

- ☐ Ulcers
- ☐ Changes in Appetite
- ☐ Nausea/Vomiting
- ☐ IBS More Constipation
- ☐ Acid Reflux Passing Gas
- ☐ Belching
- ☐ Gall Bladder Disease
- ☐ Hepatitis B or C
- ☐ Liver Disease
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Abdominal Pain
- ☐ IBS Mixed
- ☐ Loose Stools
- ☐ IBS More Diarrhea

17. **Dermatologic:**

- ☐ Rashes
- ☐ Eczema
- ☐ Breakouts from food allergies
- ☐ Vitiligo
- ☐ Facial Acne
- ☐ Back Acne
- ☐ Psoriasis
- ☐ Hives

18. **Genito-Urinary Tract:**

- ☐ Kidney Disease
- ☐ Painful Urination
- ☐ Frequent UTI
- ☐ Frequent Urination
- ☐ Interstitial Cystitis
- ☐ Kidney Stones
- ☐ Impaired Urination
- ☐ Blood in Urine
- ☐ Frequent Urination at Night

19. **Musculoskeletal:**

- ☐ Neck/Shoulder Pain
- ☐ Muscle Spasms/Cramps (if so, where?): _____
- ☐ Arm Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Leg Pain
- ☐ Joint Pain (if so, where?): _____

20. **Neurologic:**

- ☐ Vertigo/Dizziness
- ☐ Paralysis
- ☐ Numbness/Tingling
- ☐ Loss of Balance
- ☐ Seizures/Epilepsy
- ☐ Parkinson's
- ☐ Previous Stroke
- ☐ Sciatica

21. **Endocrine:**

- ☐ Hypothyroid
- ☐ Hypoglycemia
- ☐ Hyperthyroid

22. **Circadian Rhythm:**

- ☐ Insomnia
- ☐ Difficulty Falling Asleep
- ☐ Difficulty Staying Asleep
- ☐ Waking up frequently (if so, what times?) _____
- ☐ How many hours per night do you sleep? _____
- ☐ Do you wake rested? Y N

23. **Energy Level:** (10 is highest)

1 2 3 4 5 6 7 8 9 10

24. **Bowel Movement**

- ☐ Frequency _____

Stools:

- ☐ Formed
- ☐ Normal Color
- ☐ Loose
- ☐ Hard

25. **Other:**

- ☐ Anemia
- ☐ Cancer

26. **Female Reproductive:**

- ☐ Irregular Cycles
- ☐ Breast Lumps/Tenderness
- ☐ Nipple Discharge
- ☐ Heavy Flow
- ☐ Painful Periods
- ☐ PMS
- ☐ PCOS
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Bleeding Between Cycles
- ☐ Menopausal Symptoms
- ☐ Difficulty Conceiving
- ☐ Vaginal Discharge

28. **Menstrual/Birthing History:**

Age of First Menses: _____

# of Days of Menses: _____

Length of Cycle: _____

Birth Control Type: _____

# of Pregnancies: _____

# of Miscarriages: _____

# of Abortions: _____

# of Live Births: _____

29. **Male Reproductive:**

- ☐ Sexual Difficulties
- ☐ Prostrate Problems
- ☐ Testicular Pain/Swelling
- ☐ Penile Discharge
- ☐ Low Sperm Count
- ☐ Low Sperm Motility
- ☐ Sperm Morphology
- ☐ Diabetes Mellitus
- ☐ Night Sweats
- ☐ Feeling Hot or Cold
- ☐ Cold Hands/Feet

Angela Kung Acupuncture and Wellness Center, Inc.

Patient Care Financial Agreement

Dear Patient,

We want you to have a clear understanding of our policy concerning payment and insurance. Our office accepts cash, checks, Visa, MasterCard, and Discover cards.

If you are a cash patient, you will need to pay your charges in full on each visit. Cash patients receive a discounted price from the full price charged to those with insurance.

If you have health insurance: **Please bear in mind that you are ultimately responsible for payment of your charges in full at the cash rate if the insurance does not cover. Note that Copays are a fixed rate, but a coinsurance is not so we will guesstimate your payment portion until your Explanation of Benefits are received from the insurance company. Therefore you may be billed a statement or receive a credit.**

1. **Please note that insurance checks may be sent directly to you**. Any insurance checks you might receive are to be brought to our office promptly. **If you fail to do so within one week of receiving it, the check amount will be billed to your credit card.**

2. Any amount not covered by your insurance must be paid within thirty (30) days of your being notified of the amount. **Amounts owed over thirty (30) days will be charged to your credit card.**

I, _____(print name), have read and agree to this financial agreement.

Signature_____ Today's Date_____

I hereby authorize Angela Kung Acupuncture and Wellness Center to bill my credit card for amounts unpaid by insurance as specified above.

☐ MasterCard ☐ Visa ☐ Discover

Print name as it appears on credit card: _____

Credit Card Number: _____

Exp Date: _____ **CVV:** _____ **Zip Code:**_____

Signature: _____ **Date:** _____

Angela Kung Acupuncture and Wellness Center, Inc.

Informed Consent to Acupuncture Treatment and Care

Patient's Name_____

I hereby request consent to the performance of procedures that are within the scope of practice of Angela Kung and the licensed staff members of Angela Kung Acupuncture & Wellness Center, Inc., as licensed acupuncturists, on me (or on the patient named above, for whom I am legally responsible).

I have had the opportunity to discuss with a licensed acupuncturist on staff the nature and purpose of acupuncture and other treatments, including, but not limited to, cupping, ear candling, infrared sauna, energy healing, and Chinese herbal therapy. I understand that results are not guaranteed.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, slight bruising, tingling near the needling sites that last a few days, nausea, and infection. There have been reported instances of fainting, infections, and scarring. There have been instances reported of spontaneous miscarriage and pneumothorax. I understand that some herbs may be inappropriate during pregnancy, however I also understand that some herbs and acupuncture treatments can be helpful in promoting and maintaining pregnancy. I will notify my practitioner if I am pregnant or planning on getting pregnant. If I experience any gastrointestinal upset or allergic reactions to the herb(s), I will inform my acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the procedures within the scope of acupuncture. 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.

_____

Print Name

Signature of patient Date

Angela Kung Acupuncture and Wellness Center, Inc.

Informed Consent to Massage Therapy

Patient's Name_____

I hereby give consent to the performance of procedures that are within the scope of practice of the licensed massage therapists on me (or on the patient named above, for whom I am legally responsible) at Angela Kung Acupuncture & Wellness Center, Inc.

I have had the opportunity to discuss with the massage therapist named above the nature and purpose of massage treatments. I understand and am informed that there are some risks to treatment, and that there have been reported instances of bruising and soreness. I also take full responsibility for any complications that may result, such as miscarriage, spontaneous abortion, however I also understand that treatments can be helpful in promoting and maintaining a healthy pregnancy. I will notify my practitioner if I am pregnant or planning on getting pregnant. If I experience any negative reactions to the treatment, I will inform my therapist as soon as I can, even while during the treatment.

I do not expect the massage therapist to be able to anticipate and explain all risks and complications, and I wish to rely on the therapist to exercise judgment during the course of the procedure which the therapist feels at the time, based upon the facts then known, is in my best interest. I affirm that I have notified my therapist of all known medical conditions and injuries.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the procedures within the scope of massage therapy. 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.

List all surgeries:_____

List all Injuries:_____

List all medications: _____

_____
Print Name

Signature of patient Date

Angela Kung Acupuncture and Wellness Center, Inc.

24 Hour Cancellation Policy

Patient Name: _____

Angela Kung Acupuncture and Wellness Center has a 24-hour cancellation policy and asks that you give a 24-hour notice in advance when cancelling, rescheduling or failing to show up for an appointment. Not adhering to this policy will result in the requirement of having a credit card on file and the possibility of being charged for the fee of the treatment you had scheduled in the amount of $50. For your convenience, voicemail and email are available 24/7.

I have read and understood the cancellation policy above.

_____
Print Name

Signature of patient Date