Acupuncture Patient Information Form

475 North Bridge Street Bridgewater, NJ 08807, 2nd Floor
Office: 908-429-9990 Fax: 908-393-6714 nuyuacup@aol.com http://wp.nuyuacu.com/

Patient Last Name	First Name	M.I.	Gender M ☐ F ☐	Age	Marital Status	Date of Birth

Insured ID or SSN	Insured Last Name	M.I.	First Name	**Date of Birth**	**Best Phone# ( )** Leave Message: ☐ Yes ☐ No

Patient Address	City	State	Zip	Emergency Contact Name: Ph# ( )

Employer Name:	Insurance Company:	Is Illness or Injury related to: ☐ Work ☐ Auto ☐ Other

Do you have a secondary insurance that might cover this illness/injury? Yes ☐ No ☐	If yes, secondary Insurance Company: ID#:

How did you learn about Nu Yu Acupuncture or Dr. Lucy Liu: ____________________ **Email:**______________________________

Please List your reason(s) for this visit or your condition(s) in order of importance:	Date you first noticed:	Using a scale in which "0" is none (no pain/symptoms) and "10" is severe pain and symptoms, circle the number that best reflects your condition:	Please check the box that best represents how much of the time you feel pain or your symptom(s) for the listed reason(s):
1.________________	________	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-100%
2.________________	________	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-100%
3.________________	________	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-100%
4.________________	________	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-100%
		None--------------to--------------Severe	

For each reason or condition listed above, please mark how it happened:

1. ☐ Develop over time ☐ Illness Injury ☐ Auto Accident ☐ Other ______________________ ☐ I Don't Know
2. ☐ Develop over time ☐ Illness Injury ☐ Auto Accident ☐ Other ______________________ ☐ I Don't Know
3. ☐ Develop over time ☐ Illness Injury ☐ Auto Accident ☐ Other ______________________ ☐ I Don't Know
4. ☐ Develop over time ☐ Illness Injury ☐ Auto Accident ☐ Other ______________________ ☐ I Don't Know

For each reason or condition listed above, please check if it is Better or Worse with any of the following:

	HEAT		**COLD**		**REST**		**ACTIVITY**		**OTHER** (please describe on line below)		
	Better	Worse	Better	Worse	Better	Worse	Better	Worse	Better	Worse	
1.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	______________
2.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	______________
3.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	______________
4.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	______________

Please mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:

+++ Sharp or Stabbing

000 Pins and Needles

vvv Dull or Aching

/// Numbness

Please write YES where that best describes whether your pain or symptom(s) limit normal activities:

Activity	**Normal**	**Somewhat Limited**	**Severely Limited**
Lifting	________	________	________
Bending	________	________	________
Standing	________	________	________
Walking	________	________	________
Sitting	________	________	________
Climbing Stairs	________	________	________
Running	________	________	________
Resting in bed	________	________	________
Intercourse	________	________	________
Computer work/typing	________	________	________
Normal Work	________	________	________
Household Activities	________	________	________
Other	________	________	________

- Please continue on page 2 -

a. During what time of the day do you feel worse?____

b. Do you sleep well? ☐Yes ☐No What are your normal sleeping hours?_________________ to _________________

c. Are you currently under the care of a medical doctor or other type of health care provider for any condition?

☐No ☐Yes ⟶ For what condition?____

Name of Doctor/Provider____ Phone number:_____________________

d. Please list any medications you are taking, the dosage, reason for taking and the date you stated:

Medication	Dosage	Reason	Date Started

e. Please list any allergies: ____

f. Have you ever had an overnight stay in a hospital or a surgical procedure of any kind? ☐ No ☐ Yes

Event and Year:____

g. Please check the boxes that best describes your digestion: ☐ Good ☐Indigestion ☐Constipation ☐Diarrhea ☐Cravings

h. Do you exercise? ☐No ☐Yes How many days a week? _________ How many minutes per session?_________________

Questions I through K: FOR WOMEN ONLY

i. Are you currently pregnant? ☐Yes ☐No Number of pregnancies? _____ Number of births? ____ Are you nursing?☐Yes ☐No

k. **Menstrual History:** How many days from the start of your period until the start of your next period? ______________________

Date of last period? ___________ How many days did it last? ____ ☐Regular ☐Irregular Any pain? ☐Yes ☐No

Is your period: ☐Scant, thin, red ☐Heavy, dark, clotted ☐Normal red flow **Where** _______________________

Personal History

The following lists a variety of conditions that patients may experience. Please read through the list and check the box and circle the word to each condition that applies to you.

Do you use a Pacemaker? Yes No

Pain in Body

☐ Neck pain with difficulty swallowing
☐ Extreme neck stiffness with pain or electric shocks
☐ Leg pain that worsens with exercise but is relieved by resting
☐ Back pain with urinary problems

Types of Pain

☐ Severe pain interrupts sleep
☐ Constant pain that doesn't improve by changing positions or lying down

Current conditions

☐Unable to balance when walking
☐Recent unexplained weight loss

☐Recent Progressive Muscle weakness or shaking
☐Loss of bowel or bladder control
☐Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
☐Recent major accident or injury
☐ Memory loss after injury

Previously diagnosed condition

☐Congenital bone or joint disorder
☐Rheumatoid arthritis
☐Severe Degenerative arthritis
☐History of compression fracture

☐History of heart attack, stroke or aneurysm, cancer, **hepatitis A,C,B**
☐Diabetes, Gout
☐**HIV/AIDS**
☐Lupus
☐ Ankylosing spondylitis
☐Immune suppression such as from chemotherapy, **organ transplant**
☐3 or more months use of steroid medications
☐**Other(s):**_____________________
____
____

Family History

☐**Autoimmune disorders** ☐**Cancer** ☐**Heart disease** ☐ **Mental illness**
☐**Arthritis** ☐**Diabetes** ☐**Kidney disease** ☐**Seizure disorder**

I certify that the above is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the Practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity for payment, utilization and/or quality review for all or a portion of my care.

Signature:____ **Today's date:**_____________________

If patient required assistance to complete, sign name and state relationship (i.e. parent, translator) below:

Name:______________________________ **Relationship:**__________________ **Today's date:**_______________

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Patient Emergency Contact Information

The information will be strictly confidential, will remain in a secure, safe location, and will be used only in a true emergency when it is not possible to communicate with the patient directly. Thank you for helping us in our caring services.

PATIENT INFORMATION

Patient: ____

Patient Line 1: _____________________________________ **Circle:** HOME WORK CELL

Patient Line 2: _____________________________________ HOME WORK CELL

Text: YES NO Email: ____

IN CASE OF EMERGENCY, NOTIFY:

Contact: ____ Relationship: ________________

Contact Line 1: ______________________________________ **Circle:** HOME WORK CELL

Contact Line 2: ______________________________________ HOME WORK CELL

Text: YES NO Email: ____

Appointment Reminders

Would you like to receive reminders for upcoming appointments?

☐ **YES**, I would like to receive reminders for upcoming appointments via text.

☐ **NO**, I do **not** wish to receive reminders for upcoming appointments.

______________________ ___________________

Signature Date

INFORMED CONSENT FOR ACUPUNCTURE AND ORIENTAL MEDICINE

I hereby voluntarily consent to receive Acupuncture and Oriental Medicine treatment for my present and future health condition. I understand that treatment will be administered by a Certified Acupuncturist CA. The treatments that will possibly be administered are described below.

Acupuncture and Oriental Medicine Treatments That May Be Administered

Acupuncture: This is a safe treatment involving the insertion of tiny sterile (and disposable) needles through the skin, which can produce a mild but temporary discomfort (usually achiness or soreness) at the acupuncture site. It can occasionally cause slight bleeding, and will rarely leave a bruise (not painful). Other possible risks from acupuncture include dizziness and fainting. I will report to the CA any dizziness or light-headedness that occur during or after an acupuncture treatment. Extremely rare risks of acupuncture (these have an extremely low incidence, especially when acupuncture is administered properly) include nerve damage, organ puncture, and infection.

Traditional Chinese Herbal Supplements: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of herbs, I understand that I should stop the herbs and that I am responsible for informing the CA of any symptoms. Some herbs may be inappropriate during pregnancy and breastfeeding. I accept full responsibility to inform the Licensed Acupuncturist of a suspected or confirmed pregnancy, or if I am a nursing mother.

Heat Treatment with TDP Lamp: This is used to warm an area of the body. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns exists.

Cupping: This involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction. Very rarely a slight bum or blister may appear due to the heat.

Gua Sha: Gua Sha is scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising at the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

Plum Blossom (or tapping): Multiple, mild needle pricks are applied in one area. Slight bleeding at the area is likely.

Electro-Acupuncture: A mild electric micro-current (similar to a TENS treatment) is used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt.

By signing below, I show that:

I have read, or had read to me, the information on this consent form

I understand the possible risks and complications involved. I have had the opportunity to discuss this consent form with my Licensed Acupuncturist. I understand that I can request more information at any time if desired.

I consent to receiving treatment that involves that above procedures.

I understand that I have the right to refuse or discontinue any treatment at any time. I understand that this refusal may affect the expected results.

____

Patient Name (please print)

____ ________________________

Patient (or Guardian) Signature **Date**

If a Guardian has signed, please print your name: ____

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Authorization for Release of Patient Information

Name of Patient: ______________________________ Date: ______________

I, the undersigned, authorize the release of and/or request access to the information specified below from the medical record(s) of the above-named patient.

AUTHORIZATION FOR THE INFORMATION TO BE RELEASED TO:

Insurance company, doctors, hospitals, attorney, self, etc.,... Initial: ______________

AUTHORIZATION FOR THE ACUPUNCTURIST TO OBTAIN:

A copy of your records. If a copy is requested, there will be a charge for completion of all forms and/or medical records copied. Copies of medical records are $10.00 for up to 10 pages; thereafter, $1.00 per page, up to a maximum of $200 for the entire record.

Initial: ______________

PATIENT PRIVACY STATEMENT:

I have been provided with, read, and understand the Patient Privacy Statement. Initial: ______________

______________________ ______________________

Signature of Patient or Legally Authorized Representative — Date

______________________ ______________________

Printed Name — Relationship to Patient

Payment and Cancellation Policy

I, the undersigned, understand that payment for all care received is my responsibility. I also understand that a 24-hour cancellation notice, whenever possible, is necessary to avoid charges. ***Payment is due at the time of service.***

______________________ ______________________

Signature of Patient or Legally Authorized Representative — Date

______________________ ______________________

Printed Name — Relationship to Patient