Healing Art
ACUPUNCTURE • MASSAGE

Healing Art Acupuncture & Massage

PATIENT RECORD

Name ____ Birth Date ________________ Sex ______
Last Name First Name

Home Address ____

City ________________________ State____________ Zip ____________ SSN _____________________

Home Phone ( ) ___________________________ Cell Phone ( ) ____________________________

e-mail address: ____

Occupation: ________________________ Employer: ______________________________________

Work Address ____

City ____ State _______________ Zip ________________

Emergency Contact _______________________________________ Phone ( ) _________________________

Spouse's Name ______________________________ Referred By _____________________________________

Insurance: Co. ____________________________________ Phone ( ) __________________________

Present Complaints ____

____

Please answer the following questions by circling the correct answer

Do you have a tendency to faint? Yes No
Do you have a pacemaker? Yes No
Do you bleed for a long time? Yes No
Have you ever had Hepatitis? Yes No

Are you HIV positive? Yes No
(Women) Are you pregnant? Yes No
What kind of medications are you on now? ________________

____

____

Our Office Policy

1. We are a provider for BCBS-FL, and Aetna Ins. Patients must file their own claims directly.

2. We do not bill insurance directly. Patients are expected to take care of their fees as services are rendered. We do not claim responsibility of collecting your insurance claim or for negotiating a settlement of a disputed claim.

3. **If you need to cancel your appointment, please inform us at least 24 hours prior to your appointment to avoid a full service charge. A missed appointment will be charged at full rates.**

4. There is a service charge of $15.00 for every returned check from the bank.

5. I authorize the release of any medical records/other information necessary to process a claim with my insurance.

6. If you are under 18 years of age, please have your parent or legal guardian sign below.

7. Healing Art Acupuncture is required, by law, to maintain the privacy and confidentiality of your protected health information. The policy is available for you to read in our waiting room or you can also request a written copy. Please ask office staff for more information.

____
Signature of Insured or Parent

Healing Art Acupuncture & Massage

Patient Information Chart

NEUROPSCHOLOGICAL

□Stress
□Anxiety
□Bad temper
□Worry
□Depression
□Cry often
□Hospitalized for emotional issues
□Considered suicide
□Physically abused
□Emotionally abused
□Sexually abused
□Mania
□ Chemothreaphy
In therapy Yes NO
□Poor memory
□Seizures
□Concussion
□Loss of balance
□Lack of coordination
□Unfocused/confused thoughts
□Cancer (type)___________

Do you feel you get adequate affection in your life?

____

____

Other: (accidents etc) ____

____

REPRODUCTIVE & GYNECOLOGICAL (Women only)

_______ # of Pregnancies
□Long periods (7 days or more)
□Short periods (3 days or less)
□Painful periods
□Painful ovulation
_____# of Births
□Irregular periods
□Clotting
□PMS- breast distension
□PMS- emotional symptoms
_____# of Miscarriages
□Vaginal discharge (color & odor)
□Yeast infections
□Menopausal symptoms
□Birth control (what type?)______

Other:____

Please let your practitioner know if there is any chance you may be pregnant today. Some acupuncture points and herbs are contraindicated during pregnancy.

I, (patients's name),_____________________________________, am notifying the Acupuncturist, Tzong Jiunn Wu of the following:

I have been evaluated by a physician or dentist for the condition being treated within six (6) months before this acupuncture treatment was performed □YES □NO

I recognize that I *should* be evaluated by a physician for the condition being treated by the acupuncturist __________
Patient's initials

I have received a referral from my chiropractor within the last 30 days for acupuncture □YES □ NO □ NA

After being referred by a chiropractor, after 30 days or 20 treatments, whichever comes firsts, if no substantial improvement occurs in the condition being treated, I understand that the Acupuncturist is required to refer me to a physician. It is my responsibility and ***choice*** whether to follow this advice.

→ ______________________________________ ______________________
Signature of Patient Date

______________________________________ ______________________
Signature of Acupuncturist Date

Healing Art Acupunture & Massage

PATIENT MEDICAL HISTORY

The following is a list of symptoms, which you may or may not have experienced:

No Mark= never experience > = Sometimes experience + = Frequently experience

CARDIOVASCULAR		RESPIRATORY		MALES ONLY	
Shortness of breath		Cough		Prostate Problems	
High Blood Pressure		Coughed up blood		Pain in Testicles	
Irregular Heart Beat		Sore Throats			
Heart Palpitations		Nasal Problems		**FEMALES ONLY**	
Dizziness		Nose Bleed			
Chest Pain or Pressure		Asthma or Wheezing		Pre-Menstrual Pain	
Leg Cramps		Pneumonia		Menstrual Pain	
		Hay fever		Irregular Menstrual Cycle	
		Bronchitis			
GASTROINTESTINAL		COPD		**MISCELLANEOUS**	
		TB			
Indigestion				Jaundice (Yellowish Skin)	
Abdominal Pain or cramps		**GENITOURINARY**		Hepatitis C	
Gall Stones				Hepatitis B	
Constipation		Kidney Stones		HIV	
Diarrhea		Frequent Urination		Memory Loss	
Blood in Bowel Movement		Painful Urination		Headaches	
Black Bowel Movement		Bloody Discharge		How frequent?	
Excess Appetite		Venereal Disease		Insomnia	
Decrease Appetite		Pain in Genital area		Fever	
Excess Thirst		Poor Bladder Control		Chills	
Loss of Thirst		Decrease Sex Drive		Night Sweats	
Nausea and Vomiting				Intolerance-Weather change	
Colitis or Diverticulitis		M**USCULO-SKELETAL**			
Belching or Burping				**OTHER**	
Heartburn		Back Pain			
Difficulty Swallowing		Arthritis		Allergic to Alcohol	
		Muscle Pain or Cramps		Allergic to Medicines	
EYES and EARS		Painful Joints		Cancer type	
Macular Degeneration		**SKIN**		Please list:	
Blurred Vision		Ulcerations			
Sudden Hearing loss		Where?			
Hearing Loss due to accident		Psoriasis			
Jaundice (yellow eyes)		Xerosis			
Ringing in the ears		Hives			