Appointment Date:

All Under Heaven Acupuncture and Oriental Medicine LLC

General Information

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Married Single Partner Divorced Widow Date of Birth _____

Work Phone_____ Home Phone_____ Mobile Phone_____

Email_____ Occupation_____

Emergency Contact _____ Referred By_____

Family Doctor_____ Contact # _____

Have you had Acupuncture or Oriental Medicine before? Yes No

Are you presently under a doctor's care? Yes No Who, and for what?_____

Are there any other therapies which you are involved in?_____ Who and for what?_____

_____

Insurance Information

(Please provide the information for items listed in **bold** only.)

Insurance Company_____ **Contact #** _____

ID #_____ Co-pay $_____ Referral? Yes No Covered %_____

Date Called_____ Contact Name_____ Deductible_____

Focus

What is your primary reason for seeking care with our office?_____

What was the initial cause?_____

When did it begin?_____

What makes it worse?_____

What makes it better?_____

How does this problem interfere with your daily activities?

- ☐ Work ☐ Standing ☐ Sexually ☐ Other
- ☐ Sleep ☐ Emotional ☐ Recreation _____
- ☐ Walking ☐ Relationship ☐ Bending _____
- ☐ Sitting ☐ Social Life ☐ Stretching _____

What have you done about this?_____

_____

Please list a health concern that is your second priority for treatment_____

_____

Please list a health concern that is your third priority for treatment_____

_____

Are you interested in: ☐ Pain Relief ☐ Performance Care ☐ Maintenance Care ☐ Other _____

☐ Preventative Care ☐ Holistic Health ☐ Stress Relief _____

☐ Oriental Nutrition ☐ Meridian Yoga ☐ Herbal Therapy _____

What are your health goals?_____

List any past or future surgeries_____

_____

List any significant trauma. When did it occur? (auto accident, emotional, traumas, sexual, etc.)_____

_____

List any exercise and sport activities you have been, or are currently involved in_____

_____

Signs and Symptoms

For each checked item below, please assign a number 1-5 according to severity. 1=mild symptoms, 5=severe symptoms

◯ Abdominal pain/distention	◯ Coughing blood	◯ Hemorrhoids	◯ Mucous in stools	◯ Seizures
◯ Abuse survivor	◯ Dark stools	◯ Heart Palpitations	◯ Muscle cramps/pain	◯ Seeing a therapist
◯ Acid regurgitation	◯ Decreased libido	◯ Hiccup	◯ Nasal congestion	◯ Short temper
◯ Acne	◯ Depression	◯ High blood pressure	◯ Neck/shoulder pain	◯ Shortness of breath
◯ Asthma	◯ Dizziness/vertigo	◯ Impotence	◯ Night sweat	◯ Sinus pressure
◯ Bad Breath	◯ Dry mouth/throat	◯ Immune deficiency	◯ Nocturnal emission	◯ Skin fungal infection
◯ Blood in stools	◯ Diarrhea	◯ Increased libido	◯ Nose bleeds	◯ Spots in eyes
◯ Blood in urine	◯ Ear aches	◯ Indigestion	◯ Numbness	◯ Sweat easily
◯ Blurry vision	◯ Enlarged thyroid	◯ Intestinal pain/cramps	◯ Odorous stools	◯ Sore throat
◯ Breast lump/pain	◯ Eye pain/strain tension	◯ Itchy eyes	◯ Pain upon urination	◯ Sudden energy drop
◯ Bruise easily	◯ Excessive phlegm	◯ Itchy skin	◯ Peculiar tastes	◯ Swollen glands
◯ Chest pains	Color of:	◯ Joint pain	◯ Poor appetite	◯ Teeth/gum problems
◯ Chills	◯ Excessive saliva	◯ Kidney stones	◯ Poor circulation	◯ Ulcerations
◯ Cold hands/feet	◯ Fatigue	◯ Laxative use	◯ Poor memory	◯ Upper back pain
◯ Concussion	◯ Fever	◯ Limited range of motion	◯ Poor sleep	◯ Urgent urination
◯ Confusion	◯ Frequent urination	◯ Loss of hair	◯ Premature ejaculation	◯ Vomiting
◯ Constipation	◯ Gas/belching	◯ Low back pain	◯ Psoriasis	◯ Wake to urinate
◯ Cough	◯ Grinding teeth	◯ Migraine	◯ Rash	◯ Weight loss/gain
	◯ Headache	◯ Mouth sores	◯ Redness of eyes	◯ Wheezing

Female Concerns

Date of last menstruation?_____ Is your cycle regular? Yes No Is your cycle painful? Yes No

Have you ever been pregnant? Yes No Birth control? Yes No How Long? _____

◯ PMS ◯ Clotting ◯ Vaginal sores ◯ Vaginal pain ◯ Discharge

Medical History

Do you have any allergies? Yes No If so, to what?_____

Do you take medication? Yes No If yes, what types and how often?_____

Do you take supplements? Yes No If so, what types and how often?_____

Please indicate if you or any family members have had any of the following:

◯ Pneumonia ◯ Tuberculosis ◯ Hepatitis ◯ Diabetes ◯ Epilepsy ◯ Kidney Stone	◯ Drug reaction ◯ Heart attack ◯ Blood transfusion ◯ Anemia ◯ Arthritis ◯ Obesity	◯ Mental breakdown ◯ Jaundice ◯ Parasites ◯ Measles ◯ Mumps ◯ Syphilis	◯ Gonorrhea/Herpes ◯ HIV/Aids ◯ High/low blood pressure ◯ Heart disease ◯ Gout	◯ Cancer ◯ Mental illness ◯ Hypo/hyper thyroid ◯ Premature graying ◯ Seizures ◯ Multiple Sclerosis

General

Do you sleep well? Yes No Do you dream? Yes No

Do you have a high point during the day? Yes No When?_____

Do you have a low point during the day? Yes No When?_____

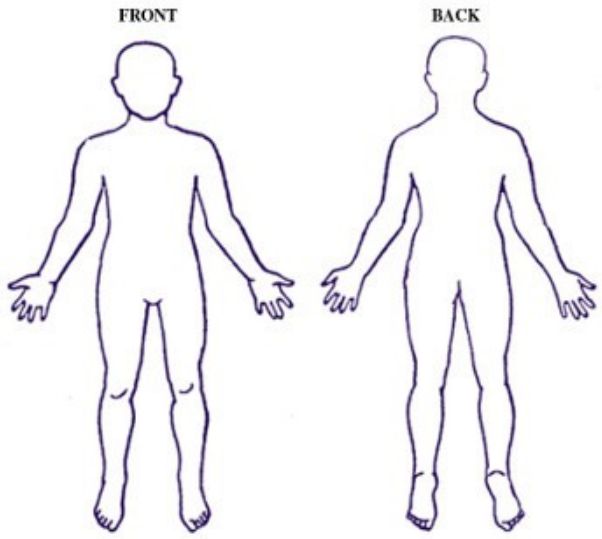
What are your indulgences?_____

What are your hobbies/pleasures?_____

Pain

Please indicate areas of pain/tension/tightness/discomfort on the chart

Pain intensity levels (please indicate below which best describe) No pain	Moderate pain	Severe pain	Terrible pain
Sleeping No problem	Mildly disturbed	Greatly disturbed	Cannot sleep
Work – Can do: Usual work	50% of work	25% of work	No work
Frequency of Pain 25% of Time	50% of Time	75% of Time	100% of Time
Travel No problem on long trips	Moderate pain on long trips		Severe pain
Recreation – Can do: All activities	Some activities		No activities
Walking Can walk any distance	Pain after ½ mile		Cannot walk
Sitting No pain sitting	Some pain while sitting		Cannot sit



How are your pain symptoms upon rising first thing in the morning? Better Worse

Please elaborate: _____

What is the quality of the pain?(please circle) Dull/Achy Sharp/Stabbing Boring Tense/Tight

Expanding/Distending Heavy Numb Other:_____

Obvious symptoms
Get me out of pain and discomfort fast!

Most patients begin acupuncture treatment to provide relief from pain, discomfort and other symptoms, fast. Acute Care helps to ease your initial problem(s) quickly.

Symptoms and Signs disappear
Feeling good, no big problems!

Maintenance Care gives you a chance for deeper healing to occur. Strengthening your body's response to illness by stimulating your natural healing capacity.

You feel great!
Feeling great!

I want to achieve optimal health and well-being, free of disease and illness. Wellness Care is your best choice.

Terms of Acceptance

Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. Acupuncturists and practitioners of Traditional Chinese Medicine (TCM) use this non-invasive medical system to help millions of people get well and stay healthy.

When a patient seeks Acupuncture care and is accepted as a patient for such care, it is essential for both patient and Acupuncturist to be working toward the same goals in order to prevent confusion or disappointment.

The main objective of Acupuncture is to determine where there are imbalances in the body as they relate to TCM. When the flow of Qi (the vital energy that flows throughout the body) is disrupted, illness and disease may occur. An imbalance in any of the 14 main Meridian channels causes an alteration in the flow of Qi through the body. This can result in a reduction in the body's innate ability to heal itself and express maximum health potential.

Once imbalances are detected, various treatment modalities may be employed to correct these imbalances. Any health condition[s] or disease[s] presented by the patient will be treated according to TCM only and treatment will relate only to the quantity, quality, and balance of Qi.

The ONLY practice objectives are to detect and correct imbalances within Meridian channels using Acupuncture and TCM techniques, to detect causative factors for the detected imbalances, and/or to detect nutritional imbalances and correct them through Whole Food supplementation.

Patients will be advised if a non-Acupuncture related or otherwise unusual finding is encountered during the course of an Acupuncture examination. If advice, diagnosis, or treatment of those findings is desired, patients will be referred to a qualified health care professional.

I _____ have read and fully understand the above statements.

All questions regarding the Acupuncturist's objectives pertaining to my care in this office have been answered to my compete satisfaction, I therefore accept Acupuncture care under these terms.

Signature_____ date_____

All Under Heaven Acupuncture and Oriental Medicine LLC

675 N. Brookfield Rd., Brookfield, WI 53045 262-439-8655

Notice of Privacy Practices

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes. Information that we use or disclose based on the authorization you are giving us may be subject to redisclosure by the person who receives the information and may no longer be protected by the federal privacy rules.

SAFEGUARDS IN PLACE AT OUR OFFICE INCLUDE:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

TYPES OF INFORMATION THAT WE GATHER AND USE:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us.
- From your medical history, treatment notes, all test results, and any letters, faxes, emails, or telephone conversations to or from your other health care providers.
- From health care providers, insurance companies, Worker's Compensation insurance providers and your employer, and other third party administrators (e.g. requests for medical records, claim payment information).

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. You may revoke your consent to us at any time: however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. This will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

I have received a copy of the Notice of Privacy Practices. I understand this notice defines my rights under the federal regulations, and is intended to comply with federal patient privacy rights.

I have read the above policies and agree to their terms. I authorize you to use or disclose my health information in the manner described above.

_____	_____	_____
PATIENT NAME (PRINTED)	PATIENT SIGNATURE	DATE