## PATIENT REGISTRATION INFORMATION

**Date:** _____

**Patient Name:** _____

**Date of Birth:** _____ **Sex:** ☐ **M** ☐ **F** **or** _____

**Street Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Home Phone: (_____)** _____

**Employer:** _____

**Work Phone: (_____)** _____

**Emergency Contact:** _____

**Relationship to Contact:** _____

**Contact Phone: (_____)** _____

**Reason Patient is Being Seen Today:** _____

**Patient Referred By:** _____

**Email Address:** _____

**MEDICAL HISTORY** (include date):

*Significant Illnesses*: _____Cancer _____Diabetes _____High Blood Pressure _____Hepatitis

_____Heart Disease _____Other

*Surgeries*:_____

*Significant Trauma*: (car accidents, falls, etc) _____

*Allergies*: (drugs, chemicals, foods, etc) _____

*Medicines taken within last 2 months*: (include vitamins, OTC drugs, herbs, etc)

Please Circle:

*Habits/Cravings*: Cigarettes Coffee Tea Alcohol Drugs Sugar Salt Soda Other: _____

Please Check: *Family Medical History*:

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Stroke ☐ Heart Disease ☐ Seizures ☐ Asthma ☐ Allergies ☐ Alcoholism ☐ Other _____

**GENERAL**:

| | | | |
|---|---|---|---|
| ☐ **Poor Appetite** | ☐ **Heavy Appetite** | ☐ **Poor Sleep** | ☐ **Heavy Sleep** |
| ☐ **Insomnia** | ☐ **Fatigue** | ☐ **Tremors** | ☐ **Vertigo** |
| ☐ **Cold Hands/Feet** | ☐ **Chills and/or Fevers** | ☐ **Night Sweats** | ☐ **Sweat Easily** |

**SKIN AND HAIR**:

| | | | |
|---|---|---|---|
| ☐ **Rashes/Hives** | ☐ **Hives** | ☐ **Loss of Hair** | ☐ **Itching** |

☐ **Other Hair/Skin Problems** _____

**HEAD, EYES, EARS, NOSE, THROAT**:

| | | | |
|---|---|---|---|
| ☐ **Dizziness** | ☐ **Migraine/Headache** | ☐ **Eye Strain** | ☐ **Poor Vision** |
| ☐ **Color Blindness** | ☐ **Cataracts** | ☐ **Blurry Vision** | ☐ **Sinus Problems** |
| ☐ **Ringing in Ears** | ☐ **Poor Hearing** | ☐ **Nose Bleeds** | ☐ **Dry Throat/Mouth** |
| ☐ **Teeth Problems** | ☐ **Gum Problems** | ☐ **TMJ** | ☐ **Facial Pain** |

☐ **Other Head/Neck Problems** _____

**CARDIOVASCULAR**:

| | | | |
|---|---|---|---|
| ☐ **High Blood Pressure** | ☐ **Low Blood Pressure** | ☐ **Chest Pain** | ☐ **Irregular Heartbeat** |
| ☐ **Dizziness** | ☐ **Fainting** | ☐ **Cold Hands/Feet** | ☐ **Swelling Hands/Feet** |

☐ **Other:** _____

**RESPIRATORY**:

| | | | |
|---|---|---|---|
| ☐ **Cough** | ☐ **Asthma** | ☐ **Bronchitis** | ☐ **COPD** |

☐ **Other Respiratory Problems:** _____

**GASTROINTESTINAL**:

| | | | |
|---|---|---|---|
| ☐ **Nausea** | ☐ **Vomiting** | ☐ **Diarrhea** | ☐ **Constipation** |
| ☐ **Gas** | ☐ **Belching** | ☐ **Hemorrhoids** | ☐ **Bloody Stool** |

**URINARY**:

| | | | |
|---|---|---|---|
| ☐ **Pain on Urination** | ☐ **Frequent Urination** | ☐ **Blood in Urine** | ☐ **Urgency to Urinate** |
| ☐ **Unable to Hold Urine** | ☐ **Kidney Stones** | ☐ **Venereal Disease** | ☐ **Impotency** |

**PREGNANCY**: **Are you pregnant now?** ☐ **Yes** ☐ **No**

| | | | |
|---|---|---|---|
| **___Number Pregnancies** | **___Number Births** | **___ Miscarriages** | **___ Age of Menopause** |

**Irregular Periods: Symptoms:** _____

**NEUROPSYCHOLOGICAL**:

| | | | |
|---|---|---|---|
| ☐ **Seizures** | ☐ **Areas of Numbness** | ☐ **Poor Memory** | ☐ **Concussion** |
| ☐ **Depression** | ☐ **Anxiety** | ☐ **Easily Stressed** | ☐ **Bad Temper** |

☐ **Other:** _____

**MUSCULOSKELETAL**:

| | | | |
|---|---|---|---|
| ☐ **Neck Pain** | ☐ **Muscle Pain** | ☐ **Back Pain** | ☐ **Joint Pain** |

☐ **Other:** _____

# Consent for Acupuncture Treatment

The practice of acupuncture is based upon Oriental medicine and is distinct and different from traditional western medicine. It involves the stimulation of specific points on the body to treat various conditions or relieve pain. The stimulation may be produced by needles, heat, digital pressure, and electrical currents, etc. Methods of treatment may include but are not limited to acupuncture, acupressure, moxibustion, bioelectrical stimulation, and cupping therapy. Acupuncture may have certain side effects including fainting, mild bruising, dizziness, bleeding, and other hazards associated with the treatment procedures. While this document describes possible risks of treatment, other side effects and risks may occur.

The acupuncturist is not practicing western medicine or making a medical diagnosis of the undersigned's condition unless additionally licensed to do so by the state as a physician and the undersigned should consult a physician if wanting to obtain a medical diagnosis.

The undersigned understands the hazards and potential dangers involved in treatment by means of acupuncture, and has been apprised of the nature and consequences of the above treatment, and is convinced that the treatment is in the best interest of the patient, but that no guarantee of results has been made. This consent form is intended to cover the entire course of treatment for any present and future conditions for which the undersigned seeks treatment by the treating acupuncturist.

The undersigned understands that insurance is not accepted, and that the undersigned accepts financial responsibility for the agreed services, with payment due at time of treatment.

*I understand that it is my responsibility to inform my treating acupuncturist(s) if I become pregnant or suspect that I am pregnant before each treatment begins.*

*I have carefully read, and I understand, the foregoing. I request and consent to the performance of acupuncture and this Oriental Medicine procedure. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time. I, hereby release Yong Oh, L.Ac., and Om Acupuncture Center from any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.*

*I am aware there is a* ***24-hour cancellation*** *policy. Patients may be charged in full if a scheduled appointment is missed or cancelled without at least 24 hours advance notice.*

Patient Name (Please Print): _____

Signature of Patient or Representative: _____

Date: _____

# Privacy Acts and Practices

This Notice describes how health information about you may be used and disclosed. They also describe how you can gain access to your health information. Please review this information carefully.

Understanding Your Health Record:
A record is made each time you visit our office for treatment. This record includes symptoms, clinician observations, diagnosis and treatment. The record may also contain other pertinent information provided by you or another of your health care practitioners with whom we may have spoken.

Your Health Information Rights:
Your health record is owned by the clinic, however, the content is always available to you for your review. You have the right to request a review of you file and to obtain copies of documents contained in your file. You also have the right to request that amendments be made to your record. In addition, you may request that the use of your information be restricted from certain uses and disclosures and to request a list of individuals or entities to whom your information has been disclosed. You may revoke any authorizations you have given regarding disclosure of your health information at any time. This revocation must be provided to us, in writing.

Our Responsibilities:
We are required to maintain the privacy of your health information and to provide you with a copy of this notice of our privacy practices. We will follow the terms of this notice and advise you if we are unable to comply with a request you may make regarding the use of your health information. We reserve the right to amend our privacy policies and we use our best efforts to notify you of any such amendments. Other than for reasons stated in this notice, we will not use or disclose your health information without your consent.

I have received, read and fully understand the Notice of Privacy Practices. I understand my health information will be used and disclosed consistent with this notice.

Signature: _____ Date: _____