Acupuncture by Maya

Patient Health History

Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Can we leave a message/text: Y N

Email: _____ Date of birth: _____

Preferred gender: _____ Marital Status: _____

Emergency Contact: _____ PH: _____ relation: _____

How did you hear about us? (please state if someone referred you): _____

_____

Are you currently receiving healthcare: Y N if yes, who? _____

If no, when and where do you last receive healthcare? _____

_____

Please identify your primary complaint (s)?

1. _____
2. _____

Please list other health concerns in order of importance:

1. _____
2. _____
3. _____

Please list your medications and over the counter medications that you are currently taking:

1. _____ 2. _____
3. _____ 4. _____

Please list any allergies or hypersensitivies (please include type of reaction):

1. _____ 2. _____
3. _____ 4. _____

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Height: _____ Weight: _____ Past max weight and when? _____

Most recent Blood pressure reading and when: _____

Have you had any imaging/testing (CAT scan, MRI, EKG) please include date, reason, and result: _____

Have you ever been hospitalized? Surgeries? (when, why and where): _____

_____

Do you have any chronic, infectious disease? _____

Do you have any reason to believe you might be pregnant? _____

Family history of diseases (please list maternal or paternal): _____

_____

Do you tend to feel warm or cold? _____

How is your energy? _____ better in am or pm? _____

Describe your bowel movement; frequency, loose or constipated: _____

Describe your mental/emotional condition: _____

Describe your sleep condition: _____

Do you smoke: Y N if yes how much: _____

Alcohol: Y N if yes, how much: _____ recreational drugs: Y N

If yes, how much: _____

How much exercise do you get and what kind: _____

_____

Describe your diet and digestion: _____

_____

Please list any other general concerns we might help you address: _____

_____

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CONSENT FORM

This is a medical consent form for the Dong Hua Acupuncture & Herbal Clinic. Please read the following statements and sign it once you feel you understand all of them.

Primary Care Providers

I understand that acupuncturists practicing in the state are not primary care providers. I understand that this clinic requires that all patients have a primary care provider as part of a conjunctive care program and that all patients provide medical records from his/her primary care providers upon request.

Procedures and Products that May Apply to Treatment

Acupuncture	Chinese Herbs
Acupressure	Moxibustion
Tuina (Chinese massage)	Cupping
Electro-acupuncture	Guasha

Potential Risks and Side Effects of Acupuncture and Chinese Medical Procedures

Local bruising	Minor bleeding
Needle sickness	Bending or breaking of needles
Pain or discomfort	Burning or scarring
Abdominal pain or discomfort	Changes in bowel movement

Record Release Authorization

I understand that I am responsible for my bill.

I authorize the use of this form for all of my insurance submissions.

I authorize release of information to all of my insurance companies.

I permit a copy of this authorization to be used in place of the original.

I direct my previous health care providers to release medical records to this clinic.

I authorize the staff of **Dong Hua Acupuncture & Herbal Clinic** to act as my agent to obtain payment from my insurance companies.

I consent to treatment with acupuncture and Chinese medicine at this clinic.

I understand that there are no guarantees concerning treatment. I understand that there may be other treatment alternatives, including treatment that might be offered by a licensed physician.

Patient signature_____ Date_____

Patient Print Name_____ Date of Birth_____

Consent to treat a Minor Child

I authorize the acupuncturist and/or whomever they designate as assistants to administer acupuncture care as deemed necessary to my:

_____(relationship)_____

Patient's Name_____

Parent or Guardian's Signature_____Date_____

Acupuncture By Maya Martinez LLC

Financial Policy

12732 SE Stark ST, Portland OR 97223, Phone 971-220-1928

Acupuncture By Maya Martinez LLC is pleased to offer our experienced practioner services to you. Payment may be in form of cash, or Visa or master cards.

If you should need to cancel or reschedule your appointment, we ask you do so at least **24 hrs before appointment time.**

We understand that some circumstances can cause a change in appointment on the same day. Therefore, we will allow 1 same day cancellation due to an emergency. Any other same day cancellations we will charge a **$25 fee per same day cancellation.**

A finance charge will accrue on all account not paid within 30 days of the invoice date.

I have read, I understand, and I agree to the above information:

Print Name _____

Signature _____

Date _____