

Dan Tian Wellness & Natural Medicine

Edith Chan, L.Ac., DAOM(c)

New Patient Questionnaire

Date of Initial Appointment: _____

Patient Information

Last Name:	First Name:	Middle:
Address:		
City, State:		
Tel. – Home:	Work:	Mobile:
Fax:	Email:	
Would you like to receive email reminders prior to appointments? <input type="checkbox"/> Yes. <input type="checkbox"/> No.		
Date of Birth:	Age:	Occupation:
Employment Status (check all that apply): <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Student		
Emergency Contact:	Relationship:	Phone:
Referred by:		
Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Other: _____		

Confidentiality: Your patient records and information will be kept strictly confidential and will only be shared when necessary to provide your care, or under your written authorization, or when required by law.

Primary Care Physician Information

Primary Physician:	Telephone:
Physician's Address (or name of clinic/hospital):	

Insurance / Superbill Information (if applicable)

Insurance Company:	Policy Holder Name:	Relationship to Patient:
Insurance Company Address:		Telephone:
Policy # / ID #:	Group #:	

Note on Insurance: Full payment is due at the time of service. Upon request, a Superbill will be provided. A Superbill is an invoice using standardized codes for treatments received, which you can submit directly to your insurance company for reimbursements. Please call your insurance carrier to find out about your insurance plan's coverage for acupuncture and related services.

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General Health & Treatment Information (please continue on back side of page as needed)

Chief Complaint – What health issue would you like to have treated? How long since onset? Pls describe.	
What makes it better?	What makes it worse?
Have you received any treatments for this health issue? Please describe. [] Yes [] No	
Have you ever had acupuncture before? If so, for what condition(s)? [] Yes [] No	
Are you presently being treated for any (other) medical conditions? Please describe. [] Yes [] No	
Please list/describe other health concerns, in order of importance.	
Are you on a special or restricted diet? (e.g. vegetarian, vegan, low-carb, raw, Atkins, Zone, etc...)	
Typical daily diet: Breakfast: _____ Morning Snack: _____ Lunch: _____ Afternoon Snack: _____ Dinner: _____ Evening Snack: _____ Average daily water intake (# of glasses): _____	
Do you exercise regularly? Please describe your program of exercise. (If competitive athlete – please briefly describe training regiment and list major upcoming events.)	

Medications/Herbs/Supplements (list any you are currently taking):

Medication:	Herbs:	Vitamins/Supplements:
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Please list any known Drug or Food Allergies:

Drugs Allergies:	Food Allergies:
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Habits (Pls check any that apply to you, past or present):

Coffee:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cups per day/wk:	Age Started:	Age Quit:
Tobacco:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cigarettes per day:	Age Started:	Age Quit:
Alcohol:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glass per day/wk:	Age Started:	Age Quit:
Marijuana:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Use per day/wk:	Age Started:	Age Quit:
Other: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Use per day/wk:	Age Started:	Age Quit:
Other: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Use per day/wk:	Age Started:	Age Quit:
Other: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Use per day/wk:	Age Started:	Age Quit:
Other: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Use per day/wk:	Age Started:	Age Quit:

Major Hospitalizations (for serious injuries or illness):

Year:	Operation / Illness:	Hospital:	City/State:
Year:	Operation / Illness:	Hospital:	City/State:
Year:	Operation / Illness:	Hospital:	City/State:
Year:	Operation / Illness:	Hospital:	City/State:

Pregnancy History

Total number of pregnancies:			
# Living:	# Ectopic:	# Miscarriage:	# Induced Abortions:

Family Health History (place **X** where applicable)

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood Disorder/Anemia							
Diabetes (specify Type 1 or 2)							
Cancer or Tumors							
Seizures							
High Blood Pressure							
Cholesterol							
Heart Disease							
Stroke							
Kidney or Bladder Disorder							
Stomach/Intestinal Disorder							
Drug/Alcohol abuse							
Tuberculosis							
Hepatitis (specify type if known)							
HIV / AIDS							
Autoimmune diseases							
Depression / Mental Illness							
Family member Age at death							
Other: _____							
Other: _____							
Other: _____							

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Patient Informed Consent Agreement:

I agree to receive acupuncture treatments and related therapies by Edith Chan, L.Ac.. Treatment methods may include, but are not limited to, acupuncture, Tui-Na massage and bodywork, cupping therapy, herbal medicine, nutritional supplements, heat and moxibustion therapy, electro-stimulation, physiotherapy exercises, as well as lifestyle and nutrition counseling.

I have been informed that acupuncture is very safe, but it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and in rare cases dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture. Infection is also a possible risk. However, I understand that Edith Chan, L.Ac. uses only sterile disposable single-use needles, and maintains a clean and safe environment. Tui-Na massage therapy is very safe but may lead to temporary muscle soreness, redness, or bruising. Burns and scarring are potential risks of heat or moxibustion therapy. Bruising is a common side effect of cupping.

The herbs and nutritional supplements used in Chinese Medicine are considered safe but may have potential side effects. I understand that some herbs may be toxic at large doses, and some herbs may be inappropriate to take during pregnancy. I will notify Edith Chan, L.Ac. immediately if I notice any unanticipated or unpleasant side effects associated with the consumption of herbal medicine or nutritional supplements.

I do not expect Edith Chan, L.Ac. to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on her to exercise judgment during the course of treatment to make decisions that are in my best interest, based upon the facts then known.

I will notify Edith Chan, L.Ac. if I am or become pregnant.

I understand that the clinical and medical staff may review my files but all my records will be kept confidential and can only be released under my personal written consent, or when required by law.

If I am unable to make a pre-scheduled appointment, I agree to cancel at least 24 hours in advance. I understand that failure to do so will result in my being **charged the full amount** of the treatment price. I also understand that if I am more than 15 minutes late to an appointment, the remainder of my time-slot may be given to another client.

I understand that Edith Chan, L.Ac. has the right to refuse treatment to any patient at anytime. Reasons for refusal of treatment include crude behavior or inappropriate conduct.

By voluntarily signing below, I show that I have read (or have had read to me) and understood this consent to treatment. I have been told about the risks and benefits of acupuncture and related therapies and have had an opportunity to ask questions. This consent form shall cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Print Name of Patient (and Representative)

Edith Chan, L.Ac.
Print Name of Practitioner

X _____
Patient Signature

X _____
Edith Chan, L.Ac.

Today's Date