

PATIENT REGISTRATION

PATIENT INFORMATION

Name _____ Sex: M F Birthdate _____ Age _____

Address _____ Occupation _____

City _____ Zip _____ Employer _____

How did you hear about us?

- Friend (name) _____
- Online Search
- Website _____
- Newspaper Ad
- Magazine Ad
- Doctor _____
- Other _____

CONTACT INFORMATION

(check preferred phone # to reach you)

- Home _____ Cell _____
- Work _____ Ext _____
- Email Address _____
- Emergency Contact (name) _____
- Relationship _____ Phone # _____

PATIENT CONDITION

Reason(s) for Visit _____

When did symptoms begin? _____

How often do you have these symptoms? _____

Does it interfere with your Work Sleep Daily Routine Recreation

What treatment have you already received for this condition?

- Medical Chiropractic Massage None Other _____

Name and address of health care providers who have treated you for your condition _____

Name and address of primary care physician (if not given above) _____

_____ Phone _____

MEDICATIONS (please list)

ALLERGIES

VITAMINS/HERBS/SUPPLEMENTS

Hospitalizations and/or Surgeries _____

Head, Eye, Ear, Nose, Throat (please circle any that you have experienced in the past 6 months):

Impaired Vision	Tearing/Dryness	Impaired Hearing	Ear Ringing	Earaches
Headaches	Sinus Problems	Nose Bleeds	Teeth Grinding	TMJ/Jaw Problems

15. **Respiratory** (please circle any that you have experienced in the past 6 months):

Pneumonia	Frequent Common Colds	Difficulty Breathing	Emphysema
Persistent Cough	Asthma	Tuberculosis	Shortness of Breath

16. **Cardiovascular** (please circle any that you have experienced in the past 6 months):

Heart Disease	Chest Pain	Swelling of Ankles	High Blood Pressure
Palpitations/Fluttering	Stroke	Heart Murmurs	

17. **Gastrointestinal** (please circle any that you have experienced in the past 6 months):

Ulcers	Changes in Appetite	Nausea/Vomiting	Epigastric Pain	Excessive Gas	Heartburn
Excessive Belching	Gall Bladder Disease	Liver Disease	Hepatitis B or C	Abdominal Pain	

18. **Genito-Urinary Tract** (please circle any that you have experienced in the past 6 months):

Kidney Stones	Painful Urination	Frequent UTI	Frequent Urination	Heavy Flow
Kidney Stones	Impaired Urination	Blood in Urine	Frequent Urination at Night	

20. **Menstrual/Birthing History:**

1. Age of First Menses: _____	4. Birth Control Type: _____	7. # of Abortions: _____
2. # of Days of Menses: _____	5. # of Pregnancies: _____	8. # of Live Births: _____
3. Length of Cycle: _____	6. # of Miscarriages: _____	

22. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain	Muscle Spasms/Cramps	Arm Pain	Upper Back Pain	Mid Back Pain
Low Back Pain	Leg Pain	Joint Pain (if so, where?): _____		

23. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness	Paralysis	Numbness/Tingling	Loss of Balance	Seizures/Epilepsy
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24. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid	Hypoglycemia	Hyperthyroid	Diabetes Mellitus	Night Sweats	Feeling Hot or Cold
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25. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia	Cancer	Rashes	Eczema/Hives	Cold Hands/Feet
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Is there anything else we should know?

East Side Acupuncture Cancellation Policy

We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all clients, the following policies are honored:

24 Hour Advance Notice

Is required when cancelling any appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give us 24 hours advance notice you will be charged **50% of the amount of** your appointment. This amount must be paid prior to your next scheduled appointment.

No-shows

Anyone who either forgets or consciously chooses to miss their appointment for whatever reason will be considered a "no-show." They will be charged the **full amount** for their "missed" appointment.

Late Arrivals

If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, **you will be responsible for the "full" session.** Out of respect and consideration to your therapist and other customers, **please** plan accordingly and be on time.

Insurance Patients

The policies stated above will not be billed to your insurance and are your responsibility to pay out-of-pocket.

We look forward to serving you!

Signature: _____ Date: _____

ADVISORY TO CONSULT A PHYSICIAN

We, the undersigned, do affirm that _____ (the patient) has been advised by Casey Lewis, LAc, to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

(Signature)

(Date)

INFORMED CONSENT

I, _____ (name) hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Casey Lewis and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for Casey Lewis, including those working at East Side Acupuncture, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental massage), Oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

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

Patient Signature (or patient representative; indicate relationship if signing for patient)

Date

Casey Lewis, LAc

Signature

Date

Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by East Side Acupuncture for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at East Side Acupuncture may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. East Side Acupuncture is not required to agree to the restrictions that I may request. However, if East Side Acupuncture agrees to a restriction that I request, the restriction is binding upon East Side Acupuncture.

I have the right to revoke this consent, in writing, at any time except to the extent that East Side Acupuncture has taken action in reliance on this consent.

My identifiable health information means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review East Side Acupuncture's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of East Side Acupuncture. This Notice of Privacy Practices also describes my rights and the duties of my practitioners with respect to my identifiable health information.

East Side Acupuncture reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by requesting the most current notice during any office visit.

Signature of Patient or Authorized Representative

Date

Printed Name and Relationship