Able Acupuncture
AND HERBAL MEDICINE

Phone: 206-462-1330
Fax: 425-449-4085

PATIENT INFORMATION

Name: _____

Phone: Home _____ Cell _____

Address: _____City & State: _____ ZIP: _____

Age: _____ Date of Birth: _____

Gender: **M** or **F** Family Physician: _____ Referred by: _____

Employer Name & Address: _____ Occupation: _____

In emergency, notify: _____ Relation to Patient: _____

How did you hear about us? Doctor:_____ Friend:_____ Website: ____ Marital Status: _____

E-Mail _____

INSURANCE INFORMATION

Person responsible for account: _____ Relation to Patient: _____ Birth date: _____

Address (if different from patient's): _____

City & State: _____ ZIP: _____

Phone: Cell_____ Home _____ Work _____

Insurance Company: _____ Policy #: _____

Contract #: _____ Group #: _____ Subscriber #: _____

Is your condition related to employment? **Y** or **N** Is your condition related to an auto accident? **Y** or **N**

Accident Claim Information

Company handling accident claim: _____

Claim #: _____

Claim Handler's Name: _____

Phone number: _____ Fax: _____

Address: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have (has) insurance coverage with _____ and assign directly to Lee Huang, L.Ac. and/or Jana Wells, Dipl. O.M., L.Ac, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. Regardless of copayment or coinsurance owed, I understand this charge might be higher due to initial consultation and/or return visits. I hereby authorize Lee Huang, L.Ac. and/or Jana Wells, Dipl. O.M., L.Ac, to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature Relationship Date

HEALTH HISTORY

Have you ever received acupuncture or oriental medicine treatments before? **Yes** or **No**

What are your main health concerns you would like help with at this time? _____

_____

How long ago did this problem begin? _____

To what extent does this problem interfere with your daily activities? (work, sleep, sex) _____

_____

Have you been given a diagnosis for this problem? If so, what? _____

_____

What kinds of treatments have you tried? _____

_____

PAST MEDICAL HISTORY

Cancer _____ Diabetes _____ Hepatitis _____ High Blood Pressure _____ Heart Disease _____

Rheumatic Fever _____ Thyroid Disease ____ Seizures _____ Other_____

Surgeries (Type and date) _____

Significant trauma (auto accident, falls, etc.) _____

FAMILY HISTORY

Cancer _____ Diabetes _____ High Blood Pressure _____ Heart Disease _____

Stroke _____ Seizures _____ Asthma _____ Allergies _____ Arthritis _____

Migraines _____ Other _____

MEDICATIONS

Drugs _____

Vitamins _____

Herbs _____

ALLERGIES

Drugs _____

Foods _____

Chemicals _____

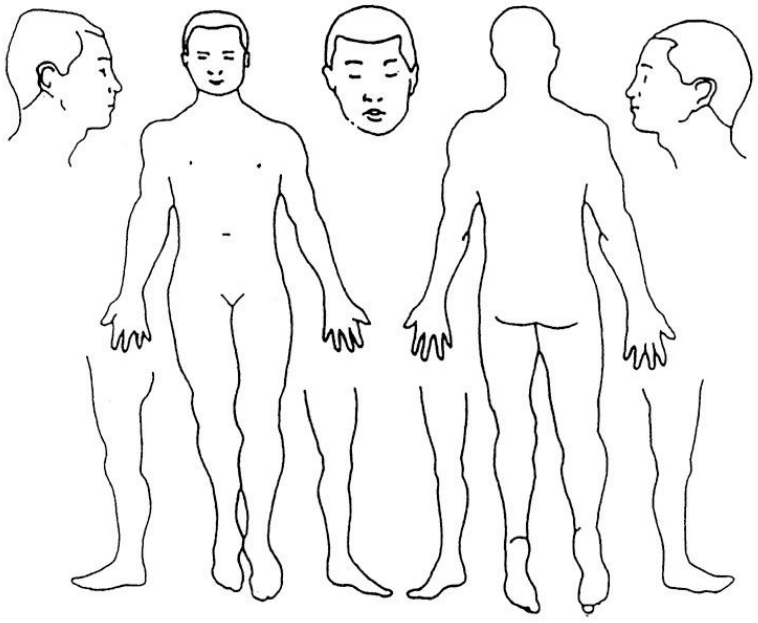
HEALTH HABITS

Caffeine _____ Tobacco _____ Drugs _____ Cigarettes _____

Please note the degree of severity of your problem now:

| _____|

No problem **Worst pain imaginable**



Please tell us any other problems you would like to discuss: _____

_____

GENERAL:
- ❑ Chills
- ❑ Fevers
- ❑ Hot Flashes
- ❑ Sweat easily
- ❑ Night sweats
- ❑ Fatigue
- ❑ Sudden energy drop? *What time of day* _____
- ❑ Cravings
- ❑ Poor sleeping

SKIN AND HAIR:
- ❑ Rashes
- ❑ Itching
- ❑ Pimples
- ❑ Eczema
- ❑ Herpes
- ❑ Loss of hair
- ❑ Other hair or skin problems _____

HEAD, EYES, EARS, NOSE, AND THROAT:
- ❑ Dizziness
- ❑ Migraines
- ❑ Headaches, where and when _____
- ❑ Poor vision
- ❑ Eye strain
- ❑ Blurry vision
- ❑ Eye pain
- ❑ Spots in front of eyes
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Earaches
- ❑ Sinus problems
- ❑ Nosebleeds
- ❑ Grinding teeth
- ❑ Jaw clicks
- ❑ Facial pain
- ❑ Sore throat
- ❑ Sores on lips or tongue
- ❑ Other head problems: _____

CARDIOVASCULAR:
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Irregular heartbeat
- ❑ Rapid heartbeat
- ❑ Cold hands or feet
- ❑ Swelling of hands or ankles
- ❑ Chest pain
- ❑ Other heart or circulatory problems: _____

RESPIRATORY:
- ❑ Cough
- ❑ Coughing blood
- ❑ Production of phlegm
- ❑ Difficulty in breathing
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Asthma

GASTROINTESTINAL:
- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Excessive thirst
- ❑ Thirst, no desire to drink
- ❑ Nausea or vomiting
- ❑ Belching
- ❑ Abdominal pain or cramps
- ❑ Bloating
- ❑ Gas
- ❑ Constipation
- ❑ Chronic laxative use
- ❑ Black stools
- ❑ Blood in stools
- ❑ Hemorrhoids
- ❑ Other stomach or intestinal problems: _____

GENITO-URINARY:
- ❑ Pain on urination
- ❑ Urgency to urinate
- ❑ Frequent urination
- ❑ Unable to hold urine
- ❑ Blood in urine
- ❑ Impotency
- ❑ Sores on genitals
- ❑ Do you wake up to urinate? **Y** or **N**
- ❑ How often?_____
- ❑ Any particular color to your urine?_____

GYNECOLOGICAL:
- ❑ Number of pregnancies
- ❑ Number of births _____
- ❑ Premature births _____
- ❑ Miscarriages _____
- ❑ Abortions _____
- ❑ Age at first menses ____
- ❑ Period between menses _____
- ❑ Duration _____
- ❑ First date of last menses _____
- ❑ Irregular periods
- ❑ Changes in body/psyche prior to menstruation
- ❑ Vaginal discharge
- ❑ Vaginal sores
- ❑ Breast lumps
- ❑ Do you practice birth control? _____
- ❑ What type and for how long? _____

MUSCULO-SKELETAL:
- ❑ Neck pain
- ❑ Back pain
- ❑ Hand/wrist pain
- ❑ Shoulder pain
- ❑ Knee pain
- ❑ Foot/ankle pain
- ❑ Hip pain
- ❑ Muscle pains
- ❑ Muscle weakness
- ❑ Muscle numbness

NEUROPSYCHOLOGICAL:
- ❑ Bad temper
- ❑ Depression
- ❑ Anxiety
- ❑ Easily susceptible to stress
- ❑ Poor memory
- ❑ Loss of balance
- ❑ Seizures
- ❑ Have you ever been treated for emotional problems? **Y** or **N**