Able Acupuncture
AND HERBAL MEDICINE

Phone: 206-462-1330
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EYE 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**

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. 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. 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

MEDICATIONS

Drugs ____

Vitamins____

Herbs ____

ALLERGIES

Drugs ____

Foods ____

Chemicals____

HEALTH HABITS

Caffeine ______________ Tobacco _____________ Drugs ______________ Cigarettes _____________

Briefly describe the main reason for having treatment today:

____
____
____
____

Have you had any previous treatments for eye issues?

____
____
____

Other eye issues or problems?

____
____
____

I currently wear glasses/reading glasses: ☐Full time ☐Part-time

If Part-time, how often/when? ___________________

I currently wear contacts: ☐Full time ☐Part-time

If Part-time, how often/when? ___________________

EYES:	**L**	**R**
Blurry vision	❑	❑
Loss of vision	❑	❑
Distorted vision/halos	❑	❑
Double vision	❑	❑
Dryness	❑	❑
Mucous discharge	❑	❑
Redness	❑	❑
Itchy	❑	❑
Burning	❑	❑
Excess tearing/watering	❑	❑
Glare/light sensitivity	❑	❑
Infection of eye or lids	❑	❑
Styes or Chalazion	❑	❑
Flashes/floater	❑	❑

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**