Alternative Medical Clinic – Richard C. Hsu, L.Ac.

New Patient Registration

Name:_____Email:_____
Telephone: *day:*_____*eve:*_____*cell:*_____
Address:_____
City:_____State:_____Zip:_____
Birth Date:_____Age:_____Sex (M/F):_____Height:_____Weight:_____
S.S.#:_____Driver's License #:_____State:__Expire:_____
Marital Status (M/S/D/W):_____Spouse Name:_____
Children: *# of boys*_____# of *girls*_____Other dependents:_____

Heard of/Referred by:_____
Emergency Contact:_____Phone:_____

Patient's (or Parent/Guardian) Employer:_____
Occupation:_____Work Phone:_____
Work Address:_____
Spouse's Employer:_____
Spouse's Occupation:_____Work Phone:_____
Spouse's Work Address:_____

Name of Person financially responsible:_____
(If Patient is a minor under 18 years of age, please fill in parent/guardian's work information above.)
Address (if different than above):_____
Phone (if different than above):_____

Medical Insurance (Yes/No):____Insurance Co.:_____
I.D.#:_____Group #:_____
Insurance Co. Address:_____
Name of Insured:_____Phone #:_____
Birth Date of Insured:_____S.S.# of Insured:_____
If applicable:
Secondary Insurance (Yes/No):____Insurance Co.:_____
Insurance Co. Address:_____
Name of Insured:_____Phone #:_____
Birth Date of Insured:_____S.S.# of Insured:_____

Primary Area of Concern:_____
_____
_____
_____

Secondary Concern:_____
_____
_____
_____

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Personal History

Childhood diseases (mark "X"): Measles_____Mumps_____Chicken Pox_____Other_____
Unusual childhood diseases: (name):_____
Smoking: how many?_____Coffee: how much?_____Alcohol: how much?_____
Medications – list names:_____
_____
Vitamins/Dietary Supplements – list types:_____
_____
Exercise – list activities & frequency of each:_____
_____
_____
Hobbies (if applicable):_____
Are you pregnant now (Yes/No)?_____Due Date:_____
Date of last menstrual period (day 1):_____# of days in menstrual cycle:_____
Do you have a pacemaker?_____List any other surgically implanted devices_____

Past History

List any previous significant injuries (slips, falls, auto accidents, etc.) and give dates of occurrences:_____
_____
_____
_____
Have you had previous back trouble (Yes/No)_____Describe and give dates of occurrence(s):_____
_____
_____
List past significant illness:_____
List all operations and provide dates:_____
List any known allergies:_____
List all abnormalities:_____
Have you received Acupuncture before (Yes/No):___Results:_____
Date of last physical exam:_____Findings:_____
_____
X-rays taken in the past 2 years (Yes/No)___Which body regions?_____
If you suffer from exhaustion or fatigue, describe in your own words how you feel and what time of day or night you experience these symptoms, including whether they occur daily, occasionally, etc.
Would you say that you are under a lot of stress (Yes/No):____If yes, describe:_____
_____
_____
Do you experience undue worry, difficulty in concentrating, forgetfulness, failing memory, etc. – please describe:___
_____
_____
Females: Do you experience any pain or discomfort before, during or after menstrual cycle?_____
Do you experience any discomforts during the cycle week (regardless of weather you menstruate, are in menopause, or have had surgical removal of all or part of the female reproductive organs or skip your periods periodically):_____
_____During the week are you "grouchy"?_____Irritable?_____
Do you have crying spells?_____Feel uptight, nervous?_____ Indicate any other problems:_____
_____
_____
_____

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Please note the degree of severity of your problem now:

|----------|

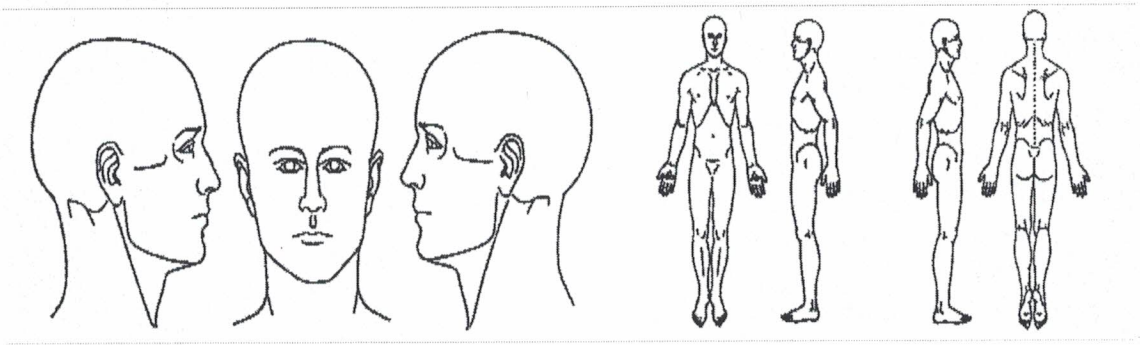
No problem (0) Worst Imaginable (10)

Please note the greatest degree of severity of your problem within the last week:

|----------|

No problem (0) Worst Imaginable (10)

Indicate the area(s) of pain or distress (mark with "X"):



Comments:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Printed Name of Patient or Authorized Representative and Relationship

_____

Signature of Patient or Authorized Representative **Date**

Alternative Medical Clinic
Acupuncture Treatment Consent Form

Patient Information and Consent Form

Please read this information carefully, and ask your practitioner if there is anything that you do not understand.

What is acupuncture?
Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body.

Is acupuncture safe?
Acupuncture is generally very safe. Serious side effects are very rare – less than one per 10,000 treatments.

Does acupuncture have side effects?
You need to be aware that:

drowsiness occurs after treatment in a small number of patients, and, if affected, you are advised not to drive;

minor bleeding or bruising occurs after acupuncture in about 3% of treatments;

pain during treatment occurs in about 1% of treatments;

existing symptoms can get worse after treatment (less than 3% of patients). You should tell your acupuncturist about this, but it is usually a good sign;

fainting can occur in certain patients, particularly at the first treatment.

In addition, if there are particular risks that apply in your case, your practitioner will discuss these with you.

Is there anything your practitioner needs to know?
Apart from the usual medical details, it is important that you let your practitioner know:

if you have ever experienced a fit, faint or funny turn;

if you have a pacemaker or any other electrical implants;

if you have a bleeding disorder;

if you are taking anti-coagulants or any other medication;

if you have damaged heart valves or have any other particular risk of infection.

Single-use, sterile, disposable needles are used in the clinic.

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having acupuncture treatment. I understand that I can refuse treatment at any time.

Signature .....

Print name in full .....

Date .....