



# Chinese Acupuncture and Herbology Clinic

## Patient Insurance & General Information

### GENERAL PATIENT INFORMATION

Date: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Marital Status: \_\_\_\_\_ DOB: \_\_\_\_\_

Preferred Phone \_\_\_\_\_ (H/C/W) Secondary Phone \_\_\_\_\_ (H/C/W)

Address \_\_\_\_\_  
(street) (city) (state) (zip)

Email address: \_\_\_\_\_  Check here to receive our newsletter.

Emergency Contact: \_\_\_\_\_  
(Name) (Relationship) (Phone Number)

Your Primary Care Physician \_\_\_\_\_

Who can we thank for referring you? \_\_\_\_\_

### PATIENT INSURANCE INFORMATION

*\*We do not accept all insurance policies. Please read and understand our policy, which is in this packet.*

Insured's ID Number \_\_\_\_\_ Insured's Policy Number \_\_\_\_\_

Insurance Plan Name or Program Name \_\_\_\_\_

Patient Relationship to Insured (circle one)    Self                  Spouse                  Child

If Relationship to Insured is other than "Self" What is Insured's Name? \_\_\_\_\_

### Present Health Concerns

Please list most important health  
Concerns in order of significance

Prior diagnosis of this problem?  
If so, what?

1. \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

4. \_\_\_\_\_

\_\_\_\_\_

5. \_\_\_\_\_

\_\_\_\_\_

FOR OFFICE USE ONLY:    ICD-9 Codes: \_\_\_\_\_    1<sup>st</sup> Treatment Date: \_\_\_\_\_





# Chinese Acupuncture and Herbology Clinic

369 Montford Ave., Asheville, NC 28801 828-258-9016  
206 Chadwick Ave., Hendersonville, NC 28792 828-698-3335  
442 Walnut St., Waynesville, NC 28786 828-452-9699

## HEALTH HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Ht/Wt: \_\_\_\_\_

Occupation: \_\_\_\_\_ Marital status: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Recent Health Care Providers: Name, Date, Service Provided: \_\_\_\_\_

Employer and Occupation: \_\_\_\_\_

**MAIN CONCERN:** \_\_\_\_\_

How does this problem affect your daily activities? \_\_\_\_\_

When did you first notice symptoms? \_\_\_\_\_

If you have been diagnosed, what is diagnosis? \_\_\_\_\_

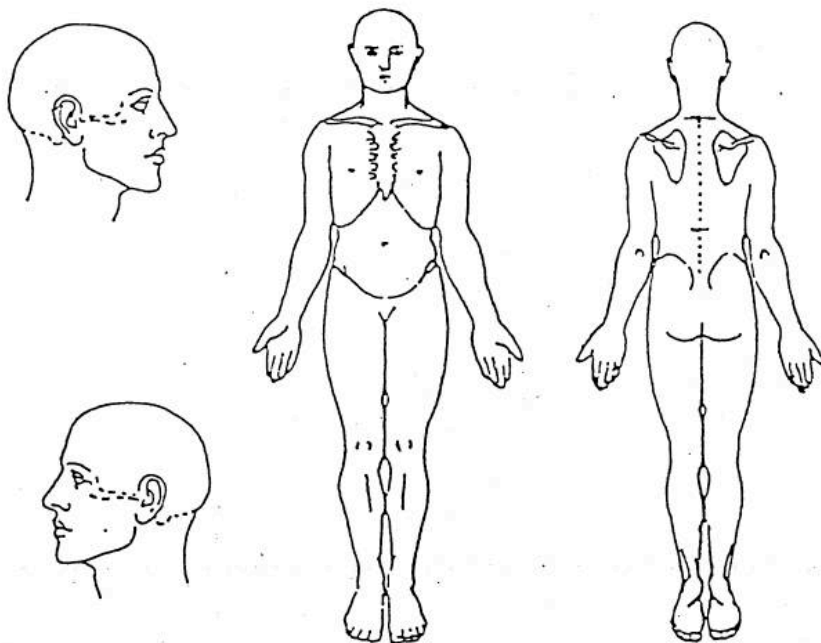
What kinds of treatment or therapies have you tried? \_\_\_\_\_

**Hospitalizations/Surgeries/Accidents:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

### Family Health History

<i>Family Member</i>	<i>Age</i>	<i>Important Diseases/Illnesses</i>	<i>Deceased Y/N</i>



Symbol	Reaction
Pain	
X	little
XX	moderate
XXX	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Pulsing	
O	slight
OO	moderate
OOO	strong
Weakness/Temperature	
~	weak
+	hot
Skin Problems	
*	skin issue

### LIFESTYLE

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise) <input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf) <input type="checkbox"/> Occasional vigorous exercise (workout/recreation, less than 4x/week for 30 min.) <input type="checkbox"/> Regular vigorous exercise (i.e., workout or recreation 4x/week for 30 minutes)
<b>Diet</b>	Are you dieting? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If yes, are you on a physician prescribed medical diet? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> # of meals you eat in an average day? _____ Describe daily diet: _____ _____
<b>Caffeine/ Alcohol/ Drugs Tobacco</b>	Indicate # of cups/cans per day <input type="checkbox"/> Coffee _____ <input type="checkbox"/> Tea _____ <input type="checkbox"/> Cola _____ <input type="checkbox"/> Tobacco _____ packs per day    Type? _____    # of years _____ Do you drink alcohol? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If so, how many drinks per week? _____ Do you use recreational drugs? Type _____ <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>

### MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## PERSONAL HISTORY

<b>General</b>	<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Night Sweats
	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Fever
	<input type="checkbox"/> Disturbed Sleep	<input type="checkbox"/> Sweating easily	<input type="checkbox"/> Chills
	<input type="checkbox"/> Localized Weakness	<input type="checkbox"/> Bleeding/bruising	<input type="checkbox"/> Sudden energy drop
	<input type="checkbox"/> Cravings	<input type="checkbox"/> Tremors	<input type="checkbox"/> Poor Balance
	<input type="checkbox"/> Strong Thirst		
<b>Skin and Hair</b>	<input type="checkbox"/> Rashes	<input type="checkbox"/> Eczema	<input type="checkbox"/> Recent moles
	<input type="checkbox"/> Ulcerations	<input type="checkbox"/> Pimples	<input type="checkbox"/> Changes in hair texture
	<input type="checkbox"/> Hives	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Hair loss
	<input type="checkbox"/> Itching		
<b>Head, Eyes, Ears, Nose, Throat</b>	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Color blindness	<input type="checkbox"/> Recurrent sore throats
	<input type="checkbox"/> Concussions	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Nose bleeds
	<input type="checkbox"/> Migraines	<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Grinding teeth
	<input type="checkbox"/> Glasses	<input type="checkbox"/> Earaches	<input type="checkbox"/> Sores on lips or tongue
	<input type="checkbox"/> Spots in front of eyes	<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Facial pain
	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Poor hearing	<input type="checkbox"/> Teeth problems
	<input type="checkbox"/> Poor vision	<input type="checkbox"/> Eye strain	<input type="checkbox"/> Headaches
	<input type="checkbox"/> Night blindness	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Jaw clicks
<b>Cardiovascular</b>	<input type="checkbox"/> Photophobia	<input type="checkbox"/> TMJ	<input type="checkbox"/> Gum/teeth problems
	<input type="checkbox"/> Dizziness	<input type="checkbox"/> High B.P.	<input type="checkbox"/> Swelling of feet
	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Fainting	<input type="checkbox"/> Blood clots
	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Cold hands or feet	<input type="checkbox"/> Difficulty in breathing
	<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Swelling of hands	<input type="checkbox"/> Phlebitis
<b>Respiratory</b>	<input type="checkbox"/> Tightening in chest	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Stroke
	<input type="checkbox"/> Cough	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Frequent colds or flu
	<input type="checkbox"/> Asthma	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Excessive phlegm
<b>Gastrointestinal</b>	<input type="checkbox"/> Nausea	<input type="checkbox"/> Belching	<input type="checkbox"/> Rectal pain
	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Black stools	<input type="checkbox"/> Hemorrhoids
	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Blood in stools	<input type="checkbox"/> Abdominal pain/cramps
	<input type="checkbox"/> Constipation	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Chronic laxative use
	<input type="checkbox"/> Gas/ Bloating	<input type="checkbox"/> Bad breath	<input type="checkbox"/> Chron's
	<input type="checkbox"/> Parasites	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Colitis
<b>Genitourinary</b>	<input type="checkbox"/> Pain on urination	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Sores on genitals
	<input type="checkbox"/> Low to no sex drive	<input type="checkbox"/> Decrease in flow	<input type="checkbox"/> Impotence/frigidity
	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Kidney stones	
<b>Musculoskeletal</b>	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Back pain	<input type="checkbox"/> Hand/wrist pain
	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Shoulder pain
	<input type="checkbox"/> Knee pain	<input type="checkbox"/> Foot/ankle pains	<input type="checkbox"/> Hip pain
	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Tendonitis	<input type="checkbox"/> Arthritis
	<input type="checkbox"/> Migraines	<input type="checkbox"/> Varicose veins	

<b>Neuropsychological</b>	<input type="checkbox"/> Seizures	<input type="checkbox"/> Poor memory	<input type="checkbox"/> Anxiety
	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Depression	<input type="checkbox"/> Bad temper
	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Concussion	<input type="checkbox"/> Frequent mood swings
<b>Other Illness</b>	<input type="checkbox"/> HIV positive	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Eating disorder
	<input type="checkbox"/> AIDS	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Jaundice
	<input type="checkbox"/> Epstein-Barr	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis
	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Underweight	<input type="checkbox"/> Overweight

**WOMEN ONLY**

Age at onset of menstruation: \_\_\_\_\_ Date of last menstruation: \_\_\_\_\_

Period occurs every \_\_\_\_\_ days

Heavy periods, irregularity, spotting, pain, or discharge? \_\_\_\_\_

Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_

Are you pregnant or breastfeeding? \_\_\_\_\_

Have you had a D&C, hysterectomy, or Cesarean?  Yes  No

Any urinary tract, bladder, or kidney infections within the last year?  Yes  No

Any hot flashes or sweating at night?  Yes  No

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?  Yes  No

Experienced any recent breast tenderness, lumps, or nipple discharge?  Yes  No

**MEN ONLY**

Do you usually get up to urinate during the night?  Yes  No

Do you feel burning discharge from penis?  Yes  No

Has the force of your urination decreased?  Yes  No

Have you had any kidney, bladder, or prostate infections within the last 12 months?  Yes  No

Do you have any problems emptying your bladder completely?  Yes  No

Any difficulty with erection or ejaculation?  Yes  No

Any testicle pain or swelling?  Yes  No

**Please list drugs, herbs and supplements you currently take:**

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# Chinese Acupuncture and Herbology Clinic

Asheville Hendersonville

## Patient's HIPAA Acknowledgement & Consent

Revised 08/16/16

I give consent to Chinese Acupuncture & Herbology Clinic for the use and disclosure of my Protected Health Information (PHI) for these specific purposes:

1. Providing treatment to me & communicating with my healthcare providers.
2. Collecting and processing payment for the services this office has rendered to me.
3. The general administrative operations this practice provides to me.

I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures form of this acupuncture practice before I sign this consent form regarding the use and disclosures of my Protected Health Information.

I understand that I have the right to revoke this consent, in writing, at any time except to the extent that the acupuncturist or the practice has acted in reliance on this consent.

### ***Acknowledgement of Receipt Of Notice of Privacy Policies***

My signature below acknowledges that the Chinese Acupuncture and Herbology Clinic has provided me with a *Statement of Privacy Policies & Office Policies*.

### ***Medical Records Release***

Release medical records To or From the Chinese Acupuncture & Herbology Clinic, & my Physician below.

Physician's Name: \_\_\_\_\_

*Expiration Date of Authorization:*

Address: \_\_\_\_\_

This authorization is effective through \_\_\_\_\_.

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

### ***Right to Terminate or Revoke Authorization***

You may revoke or terminate this authorization by submitting a written revocation to the office. Please contact the office manager to terminate this authorization.

***Signature*** \_\_\_\_\_

***Date*** \_\_\_\_\_

***Witness*** \_\_\_\_\_

ashevilleacupuncture.com

369 Montford Avenue Asheville NC 28801 828.258.9016

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# Chinese Acupuncture and Herbology Clinic

Asheville Hendersonville

## Notice Of Privacy Policies

Revised 08/2016

The Chinese Acupuncture and Herbology Clinic is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. Outlined here are policies we follow and rights to which you are entitled, according to state and federal law.

We gather personal and health information in several ways:

- Information we receive from you
- Information we receive from other healthcare providers
- Information we receive from third party payers

Please be aware that during the course of our relationship we will likely use and disclose protected health information (PHI) about you for treatment, payment, and healthcare operations. PHI is identifying information about your past and present physical or mental health condition.

You may specifically authorize us to use PHI for any purpose or to disclose the health information we have about you by submitting the authorization in writing.

### Marketing

The Chinese Acupuncture Clinic will not use your health information for marketing communications without your written authorization. We may send newsletters and appointment reminders, by calls, e-mails, post cards or letters, unless otherwise advised by you. You have the right to opt out of fundraising and marketing communications; please initial as indicated on the HIPAA Acknowledgement & Consent form.

### Disclosure

The Chinese Acupuncture Clinic may use or disclose your Protected Health Information without your express authorization only when required by law.

### Patient Rights

1. Upon written request you have the right to access, review, or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information, including restricting information released to your health insurance company regarding any services/products for which you pay in full at the time of service.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing.

*The Chinese Acupuncture and Herbology Clinic* maintains patient sign-in sheets that are visible and accessible to patients, staff and others who may enter the office. You have the right to use your first name only at sign-in.

If you have questions, complaints or want more information, please contact Joshua Herr, Practice Manager, at our clinic in Asheville. If you wish to make a formal complaint, send it to:

U.S. Department of Health and Human Services  
DHHS (Office of Civil Rights)  
200 Independence Avenue SW  
Room 509F HHH Building  
Washington DC 20201

[ashevilleacupuncture.com](http://ashevilleacupuncture.com)

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# *Chinese Acupuncture and Herbology Clinic*

Asheville Hendersonville

## **Office Policies**

Welcome to our clinic! For your convenience, we will explain our office policies so that we can serve you more efficiently. Please read the following carefully and keep for your files.

1. Please refrain from wearing perfume oils, as some of our patients are sensitive to these.
2. Please provide your practitioner with a list of any and all medications and/or supplements you are currently taking.
3. Acupuncture is a very safe medical procedure and well known for its efficacy and lack of side effects. Occasionally, bruising may occur. Do not be alarmed, but if you have questions or concerns, we encourage you to call the office.
4. We recommend relaxation and/or sleep after treatment.
5. There is a \$40 charge for cancellation of your appointment with less than 24 hours notice. At the Chinese Acupuncture Clinic, we schedule a specific amount of time for each patient to be with their practitioner. We do this because we are committed to providing the very best service. An advance cancellation notice allows an opportunity to extend services to the people on our waiting list.
6. Please be on time for your appointments. If you find that you cannot be on time please notify our office. If you are late for your appointment, the doctor may not be able to see you.
7. All herbs are paid for at the time of receipt. We can also leave herbs in the after-hours box outside the clinic or mail them to you when payment is received in advance.
8. There is a \$20 charge for returned checks.
9. We accept cash, personal check and Visa/MasterCard.
10. Please advise us of any change in your address or phone number(s).
11. As a courtesy to others, please turn your cell phone off while at the clinic, unless there is an emergency.
12. Please do not leave your children unattended.

Thank you.

[ashevilleacupuncture.com](http://ashevilleacupuncture.com)

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# Chinese Acupuncture and Herbology Clinic

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## ACUPUNCTURE INFORMED CONSENT TO TREAT

*Revised 08/2016*

I hereby request and consent to 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 the Licensed Acupuncturist at the Chinese Acupuncture Clinic.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture and the adjunct modalities are generally a safe method of treatment, but may have some side effects, including bruising, numbness or tingling near the treatment sites that may last a few days. Dizziness or fainting is a rare reaction that may occur.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that I have been prescribed are purchased from suppliers that meet current Good Manufacturing Practice (GMP) enforced by the United States Food and Drug Administration (USFDA). The most common side effects of herbal medicine are gas, indigestion, or loose stools. If I have any questions about my herbal prescription, those questions will be answered by a Licensed Acupuncturist at the CAC.

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.

I will notify a CAC acupuncturist who is caring for me if I am or become pregnant.

I understand that no promises have been made to me as to the results of treatment.

By signing below, I show that I have read, or have had read to me, the above Consent to Treat, 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 **X**

DATE

(Or Patient Representative, Indicate relationship if signing for patient)

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