Clarity Acupuncture and Herbs

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

Personal Information Date: _____

Name_____ Sex ☐M ☐F ☐Trans_____

Date of Birth _____ Age_____ Height _____ Weight_____

Occupation_____ Employer Name _____

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Living with

Home Address _____ City _____ State _____ Zip _____

Email Address _____

Tel: Cell ( )_____ Home ( )_____ Work ( )_____

Emergency Contact

Name _____ Relation _____

Phone# ( )_____ Alt. Phone # ( )_____

Insurance Information ☐None

Ins. Company: _____ Insurance Co. Phone #:_____

ID/Claim# _____Policy Group #_____ Employer/School: _____

Policy holder:_____ Relation to Pt:_____DOB_____

Phone# _____Insured Address:_____

CURRENT HEALTH INFORMATION

Reason for visit today _____

How long has this been a problem? _____

How does this interfere with your daily activities? (Work, sleep, sex, etc…) _____

_____

What Alleviates/Aggravates the Symptoms? _____

_____

Have you tried other treatments? If so, what was the Diagnosis for your problem?

_____

Date of Last Physical: _____ Physician _____

Phone number _____

MEDICINES:

Drugs you are currently taking	For what condition?

Major Hospitalizations: For any serious medical illness or operation, besides normal pregnancies

Year	Operation/Illness

FAMILY HISTORY – Complete for each family member, indicating any of the illnesses that they have had.

	Self	Mother	Father	Siblings	Grandparents	Children
Cancer or Tumors						
Diabetes						
Blood or bleeding disorders/ anemia						
Seizures						
High blood pressure/ Heart disease						
Allergies						
Stroke						
Drug/Alcohol abuse						
Depression/ Mental illness						
Hepatitis						
Kidney disorders						
Thyroid disorders						
Musculo-skeletal disorders						

PERSONAL LIFESTYLE HABITS (Please indicate what, how much, how many, or how often.)
Cigarettes_____ Coffee/Tea (cups)_____ Alcohol (drinks/wk)_____

Recreational Drugs _____ Vitamins/Herbs _____

Exercise/non-work activities _____

Dietary Restrictions/ Issues/ Cravings _____

MALE SEX HEALTH

Are you experiencing any functional problems? (Impotence, premature or nocturnal emission, etc.)

_____

Date of last digital rectal exam (DRE)_____ *Normal / Abnormal*

Lumps in testicles? *Yes / No* Libido? *Increased / Decreased*

Sexually Transmitted Diseases (STDs)? _____

GYNECOLOGY

Age of first menses _____ Date of last menstrual period _____ Duration of flow _____

Length of cycle _____ Blood clots? *Yes / No* When? _____ Pain? *Yes / No* When? _____

Texture of blood: *Normal / Thick / Thin / Watery* Color of Blood*: Pale / Bright red / Dark red / Brown*

Irregular Periods (describe) _____

PMS (describe) _____

Current contraception? _____

Last PAP smear: *Normal / Abnormal* Date: _____

Uterine fibroids? *Yes / No* Endometriosis? *Yes / No* Other?_____

Vaginal infections/discharges (describe) _____

Pain during sex? *Yes / No* Libido: *Increased / Decreased*

Breast (lumps, cysts, tenderness, etc.) _____

Urinary tract infections? *Yes / No* How frequent? _____

Sexually Transmitted Diseases (STDs)? _____

Menopause

Date: _____ Symptoms _____

Are you on hormone replacement therapy (HRT)? *Yes / No* Dose _____

Side effects? _____

Pregnancies

Are you currently pregnant? *Yes / No* Number of pregnancies _____ Live births _____

Premature births ____ Miscarriages_____ Abortions _____

Please write ***"C"*** if the condition is current, or ***"P"*** if you had it in the past

General
__ Insomnia
__Dreams / Nightmares
__Irritability
__Depression
__Anxiety
__Mood swings
__Fatigue
__Poor memory
__Strongly likes cold drinks
__Strongly likes hot drinks
__ Recent weight loss/gain
__Cold hands or feet
__Chills/fever
__Hot flashes

Head & Neck
__Headaches/Migraines
__Dizziness/Fainting
__Swollen glands

Ears
__Ringing
__Hearing loss
__Hearing aids
__Infections
__Vertigo

Eyes
__Blurred double vision
__Poor night vision
__Spots or floaters
__Eye inflammation
__Glaucoma
__Cataracts

Nose, Throat & Mouth
__Sinus infection
__Hay fever / allergies
__Frequent sore throat
__Difficulty swallowing
__Mouth & tongue ulcers
__Frequent colds
__Dry nose
__Nosebleeds
__Nasal congestion
__Loss of voice
__Thirst
__Excessive phlegm
__TMJ/Facial pain
__Gum problems
__Dry mouth

Skin
__Hives / Rashes
__Eczema / Psoriasis
__Night sweating
__Excess sweating
__Dry skin
__Easy bruising
__ Moles/lumps
__Itching
__ Lesions

Respiratory
__Difficulty breathing
__Asthma / Wheezing
__Cough
__Shortness of breath
__Tight chess
__Bronchitis
__Pneumonia

Cardiovascular
__High blood pressure
__Low blood pressure
__Chest pain
__Palpitations
__Rapid heart beat
__Slow heart beat
__Irregular heart beat
__Poor circulation
__Swollen ankles/legs
__Phlebitis
__Anemia

Gastrointestinal
__Hiccups
__Nausea / Vomiting
__Indigestion
__Stomach pain
__Poor appetite
__Excessive hunger
__Acid regurgitation
__ Bad breath
__Diarrhea
__Constipation
__Laxative use
__Blood in stool
__Mucus in stool
__Hemorrhoids
__Gas / Bloating
__Gallbladder disorder

Musculoskeletal
__Joint pain /disorder
__Sore muscles
__Weak muscles
__Difficulty walking
__Neck/Shoulder pain
__Upper back pain
__Lower back pain
__Rib pain
__Limited Range of motion

Neurological
__Seizures
__Tremors
__Numbness or tingling
__Pain
__Paralysis
__Poor coordination

Genito-urinary
__Pain in urination
__Frequent urination
__Urgent urination
__Blood in urine
__Unable to hold urine
__Incomplete urination
__Bedwetting
__Wake to urinate
__Kidney stones

Infection Screening
__ HIV (self / partner)
__TB (self / household)
__Hepatitis (self / partner)
__ Herpes (oral / genital)

Other

_____

_____

_____

_____

INFORMED CONSENT

Clarity Acupuncture and Herbs

I hereby 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 acupuncturist, Catherine Wang. Methods of treatment may include acupuncture with sterile needles, heat, moxibustion, electro-acupuncture, cupping, gua sha or other dermal friction, acupressure, breathing techniques and other exercise, or nutritional counseling based on the concepts of Traditional Chinese Medicine. I understand that no promises or guarantees can be made regarding the outcome of treatment because of the uniqueness of each individual.

I understand that acupuncture is a generally safe method of treatment, but that it may occasionally have some side effects, including bruising, numbness, tingling or pain near the needling site that may last a few days, and in rare cases, dizziness or fainting. Bruising is a common side effect of cupping and gua sha. It is not uncommon to see worsening of some symptoms for 24-48 hours before improvement of the condition treated. And as with any procedure in which the skin is broken, there is a very slight risk of infection.

I understand that acupuncture treatment is not a replacement for diagnostic medical procedures. An acupuncturist does not diagnose according to standard medical practice, nor should a "Chinese Diagnosis" be considered a replacement for standard medical evaluation or testing. I understand that it is appropriate for me to consult my primary care physician about the acupuncture treatment if I choose to do so, if circumstances warrant, or if my acupuncturist recommends such a consultation.

I understand that I should inform my acupuncturist whether I have been examined by a licensed physician with regard to my presenting complaint, and if so, what the Western medical diagnosis is. I should also report whether I have any other serious illness, a bleeding disorder or a pacemaker.

_____ _____

Patient Signature Date

_____

Patient Name (Printed)

_____ _____

Parent/Guardian Signature Date

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGMENT

Clarity Acupuncture and Herbs keeps a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels us to do so.

This Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient or Guardian Signature Date

_____

Patient name (Printed)

CLARITY ACUPUNCTURE AND HERBS

651 South Jackson St
Seattle, WA 98104

ASSIGNMENT OF INSURANCE BENEFITS
SIGNATURE ON FILE

I clearly understand that all insurance coverage, whether accident, work related or general coverage is an arrangement between my insurance carrier and myself. If this clinic chooses to bill any services to my insurance carrier that they are preforming these services strictly as a convenience for me. The clinic will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account.

I hereby authorize payment directly to Clarity Acupuncture and Herbs. I authorize Clarity Acupuncture and Herbs to act as my agent in helping me to obtain payment from the insurance company. I understand that I am financially responsible to the charges not covered by this assignment. I authorize the doctor, attorney, or insurance company to release any information required for this claim. I permit a copy of this authorization to be used in place of the original.

Name: _____

Signature: _____ Date: _____
Patient / Policy Holder