MIZU ACUPUNCTURE &WELLNESS

4179 Piedmont Avenue, Suite 101
Oakland CA 94611
(510) 999-6488

Patient Health History & Intake Form

All information provided on this form is confidential.

Welcome to Mizu Acupuncture & Wellness. As a holistic health practitioner my goal is to help you achieve optimal health in many areas of your life. I use acupuncture, herbal remedies and lifestyle and nutritional counseling. I know this form contains many questions but please take your time and answer as much as you can. The more you tell me about yourself, the better I will be able to treat you. I look forward to working with you!

Nhu Truong LAc

Today's Date: _____/_____/_____

Name:_____

Date of Birth: _____/_____/_____ Age:_____

Address:_____

City/State/Zip:_____

Email:_____

Preferred Telephone Number:_____

Occupation: _____

Emergency Contact

Name:_____

Relationship:_____

Telephone:_____

How did you hear of Mizu Acupuncture & Wellness?

_____

What are your primary health concerns you would like to address?

1._____

Date of Onset: _____/_____/_____

2._____

Date of Onset: _____/_____/_____

3._____

Date of Onset: _____/_____/_____

Who is your Primary Care Physician?

_____

Have you ever had an acupuncture treatment before? Yes / No

What medications, herbs, vitamins, supplements, etc. are you currently taking?

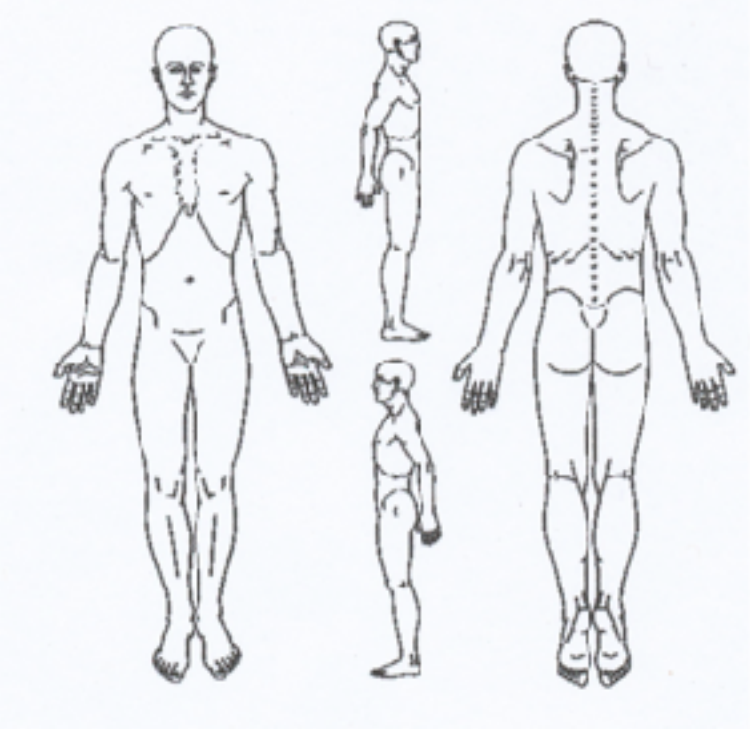
_____

_____

Please indicate if there is a history of the following diseases in you or your immediate family. If so, also list relationship:

Disease	Yes / No	Relationship
Cancer		
Stroke		
Mental Illness		
Diabetes		
Heart Disease		
High Blood Pressure		
Epilepsy		
Addiction		

Muscles, Joints & Bones:
If you are experiencing pain please indicate where by shading in the chart below, if you have additional concerns feel free to use the space beside the chart to address them.



If pain is present:

Is this a recent injury?_____

When was the onset of the injury? _____/_____/_____

The pain can be described as any of the following (circle all that apply):

Sharp Dull Aching Numb Burning Tingling Radiating

Better/Worse with Heat Better/Worse with Cold Worse in AM/PM

Better/Worse with Pressure Better/Worse with Movement

Please circle all that apply:

Tendonitis Carpal Tunnel Syndrome Muscle cramping/pain Fracture

Swollen Joints Arthritis Repetitive Strain Injury

Systems Overview General:

Weight: _____ Height_____

Weight one year ago: _____

Most recent blood pressure reading _____/_____

Date last taken _____/_____/_____

How often do you exercise? _____

Do you use tobacco currently? Yes / No

If yes, how much do you smoke daily? _____

Have you used tobacco in the past? Yes / No

If yes, how long and how much? _____

Are you allergic to any foods, drugs or environmental substances?

_____

What hospitalizations, surgeries or special medical services have you had, and when?

Date	Reason

Check any of the following you have or have had in the past year:

FEMALE ONLY	√
Irregular Cycle	
Absent Cycle	
Bleeding Between Cycles	
Clotting	
Heavy / Light Flow	
PMS	
Endometriosis	
Cramping	
Vaginal Discharge	
Ovarian Cysts	
Breast Pain / Tenderness	
Nipple Discharge	
Breast Lumps	
Menopausal Symptoms	
Low Libido	
Difficulty Conceiving	
Abnormal Pap	
STD	

Age at which menses began_____

If in menopause date of last period_____

Cycle Length: _____ days

Duration of Flow: _____ days

Date of Last Monthly Period ___/___/___

Number of Pregnancies: _____

Number of Miscarriages: _____

Do you have children? Yes / No

If Yes, what are their ages? _____

Date of last PAP ____ /____ / _____

Pregnant now? Yes / No

Do you use birth control? Yes / No

In what form? _____

History of Birth Control Pill? Yes / No

How long? _____

MALE ONLY	√
Hernia	
Testicular Swelling / Mass	
Testicular Pain	
Prostate Diseases	
STD	
Discharge / Sores	
Sexual Dysfunction	

Check any of the following you have or have had in the past year:

General	√	**Immune**	√	**Head / Neck**	√
Insomnia		Easily Catch Colds		Headache	
Fatigue		Swollen Glands		Migraine	
Chills or Fevers		Chronic Infections		Fainting	
High Stress		EBV / Chronic Fatigue		Jaw Pain	
Anemia		**Mouth / Throat**	√	Pain / Stiffness	
Circulatiuon	√	Sore Throat		**Cardiovascular**	√
Cold Hands & Feet		Teeth Grinding		High Blood Pressure	
Easy Bruising		Gum Problems		Low Blood Pressure	
Varicose Veins		Hoarseness		Heart Disease	
Respiratory	√	**Nose / Sinus**	√	Angina / Chest Pain	
Chest Congestion		Nose Bleed		Palpitation / Irregular Beat	
Wheezing		Hay Fever		Blood Clot	
Asthma		Allergies		Edema	
Difficulty Breathing		Sinus Problems		**Endocrine**	√
Shortness of Breath		**Digestion**	√	Hypo / Hyperthyroid	
Cough		Heartburn / Acid Reflux		Heat / Cold Intolerance	
Coughing Blood		Nausea / Vomiting		Hypoglycemia	
Eyes / Ears	√	Gas / Bloating		Diabetes	
Itchy Eyes		Frequent Belching		Excess Thirst / Hunger	
Dry Eyes		Diarrhea / Constipation		**Skin**	√
Red Eyes		Blood In Stool		Rashes	
Impaired Vision		Mucous In Stool		Eczema	
Floaters		Neurologic	√	Rosacea	
Catracs		Seizures		Acne	
Ringing In Ears		Numbness / Tingling		Fungal Infection	
Decreased Hearing		Vertigo / Dizziness		Lumps	
Earache / Infection		Loss of Balance		Night Sweats	

Check any of the following you have or have had in the past year:

Mental Health	√
Mood Swings	
Anxiety	
Depression	
Poor Concentration	
Easily Angered	
Panic Attacks	
Manic Behavior	
Diagnosis:	
Other:	

Please list any other concerns not addressed in the above lists and thank you for taking the time to fill out this detailed form:

_____

_____

_____

_____

_____

_____

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible for) by Nhu Truong, who is a Licensed Acupuncturist in the state of California, and or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for Nhu Truong, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

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 will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is generally a safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I have been informed the side effects of acupuncture facial rejuvenation include bruising on the face, redness on the face, and/or bleeding on the face. I understand the contradictions of facial acupuncture include high blood pressure, dizziness, diabetes, pregnancy, facial sunburn, asthma, those who have had recent Botox or Restalyn injection, microdermabrasion, chemical peel, acute herpes outbreak on the face, have a cold/flu, pituitary tumors or Cushing's disease, hemophiliacs, those on blood thinners, taking aspirin, vitamin E, and/or fish oil, those prone to migraines, epilepsy or seizers, lymphoderma in the face, cancer, AIDS, or coronary diseases. If I have any of these above conditions I will inform the acupuncturist before starting treatment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of the treatment, and I wish to rely o the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand the results are not guaranteed.

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.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, 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 conditions and for any future conditions for which I seek treatment.

Please print patient's name:

_____

Patient Signature _____ Date ____/ ____/ ____

FINANCIAL AGREEMENT, INSURANCE POLICY, & CANCELLATION POLICY

Financial Agreement

Payment is due at the time of service.
For your convenience we accept cash, check, and all major credit cards.

Insurance Responsibility Statement

Having insurance is not a substitute for payment. Many companies have fixed allowances and percentages based on your contract with them. It is your responsibility to pay the deductible, co-payment, and any other balances not paid by your insurance carrier. We will explain to the best of our ability your benefits and payment responsibilities. We will bill your insurance directly.

Assignment and Release

I hereby assign my insurance benefits to be paid directly to the provider of service. I understand that I am financially responsible for any non-covered services. I also authorize the provider to release any information required to process any claims.

Cancellation Policy

We have a 24 hour cancellation policy. We ask that if you would like to cancel that you give us at least 24 hours notification before the scheduled appointment. If a 24 hour notice is not given, you may be charged the full price of the visit for the missed appointment.

I have read and understand the financial agreement, insurance, and cancellation policy. I understand that all services that I have are my financial responsibility and due at the time of service.

Patient Signature _____

Date ____/ ____/ ____

HIPAA NOTICE

This notice describes the policy for how medical information about you may be used and disclosed, how you can get access to that information, and how your privacy is being protected.

Safeguards in place include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, phone and faxes sent are kept on permanent file. Types of information that I may gather and use:

In administering your health care, I may gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions)
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workers' compensation and your employer, and other third party administrators (e.g. requests for medical records, claim payment information)
- I value our relationship and respect your right to privacy. If you have any questions or concerns about our privacy guidelines, please call me at: (510) 999-6488.

Signature: _____

Date: ____/ ____/ ____

Print Name: _____

Date of Birth: ____/ ____/____