TARO LEAF ACUPUNCTURE
PHONE:510.730.0608
EMAIL: info@taroleafacu.com

CONFIDENTIALITY
Your patient records and information will be kept strictly confidential and will only be shared when necessary to provide care, or under your written authorization, or when required by law.

PATIENT INFORMATION (Please Print and complete in full) ____New Patient ____Established

Patients Name (First, Last)	Todays Date:
Birth Date:	Age:
Address:	Phone #:
	Gender:
Referred to clinic by:	
Emergency Contact	Relationship:
Emergency Phone #	

MAIN CONCERNS

Health goal / Chief Complaints	Severity (1-10)	How Long?
1		
2		
3		
Please describe type of pain / what relieves pain?		
What activities does your pain interfere with?		
What have you done to improve your condition / did it help?		
What are your expectations for todays visit?		

Patient Name: _____Date: _____

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GENERAL HEALTH

Energy Level (1-10 lots of energy):	Stress Level. (1-10 super stressed):
Coffee (age start /quit/amount):	Marijuana (age start /quit/amount):
Alcohol (age start /quit/amount):	Other Substances:
Do you exercise? What? How much?	
Do you enjoy work? How many hours?	
What do you LOVE to do for fun?	

HEALTH HISTORY

Hospitalizations and surgeries? (Reason and Dates)
Any serious illness, acute or chronic?
Please list any current medications, supplements, herbal remedies (dosage and purpose)
List all allergies including medications, seasonal, environmental, food:

PERSONAL OR FAMILY HISTORY

	Self	Family		Self	Family
Anemia/Blood Disorders			Heartburn / Indigestion		
Arthritis			Kidney Disease		
Breast Lumps			Liver Disease		
Cancer or Tumors			Lupus		
Convulsions or Seizers			Pacemaker		
Diabetes			Stroke		
Drug Abuse			Tuberculosis		
Depression/ Mental Illness			Other		
Heart Disease					

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GENERAL
- ☐ Low Appetite
- ☐ Excessive Appetite
- ☐ Insomnia
- ☐ Fatigue
- ☐ Fevers
- ☐ Night Sweats
- ☐ Sweat Easily
- ☐ Chills
- ☐ Localized Weakness
- ☐ Poor Coordination
- ☐ Change in Appetite
- ☐ Strong Thirst
- ☐ Other_____

SKIN AND HAIR
- ☐ Rashes
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dryness
- ☐ Tumors, Lumps

HEAD AND NECK
- ☐ Dizziness
- ☐ Fainting
- ☐ Neck Stiffness
- ☐ Enlarged lymph glands
- ☐ Headaches
- ☐ Concussions
- ☐ Other _____

EARS
- ☐ Infection
- ☐ Ringing
- ☐ Decreased hearing
- ☐ Other_____

EYES
- ☐ Blurred vision
- ☐ Visual changes
- ☐ Poor night vision
- ☐ Spots
- ☐ Cataracts
- ☐ Glasses/Contacts
- ☐ Eye inflammation
- ☐ Other_____

NOSE, THROAT, AND MOUTH
- ☐ Nose bleeds
- ☐ Sinus infection
- ☐ Hay fever or allergies
- ☐ Recurring sore throats
- ☐ Grinding teeth
- ☐ Difficulty swallowing

CARDIOVASCULAR
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Blood clots
- ☐ Palpitations
- ☐ Fainting
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Cold hands/feet
- ☐ Swelling of hands/feet
- ☐ Other_____

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ Frequent colds
- ☐ COPD
- ☐ Pneumonia
- ☐ Cough
- ☐ Coughing blood
- ☐ Production of phlegm
- ☐ Other_____

GASTRO-INTESTINAL
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Belching
- ☐ Blood in stools/black stools
- ☐ Bad breadth
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Pain or cramps
- ☐ Indigestion
- ☐ Gall bladder disorder
- ☐ Gas
- ☐ Other_____

GENITO-URINARY
- ☐ Kidney stones
- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Other_____

MALE
- ☐ Pain /itching of genitalia
- ☐ Genital lesions / discharge
- ☐ Impotence
- ☐ Weak urinary stream
- ☐ Lumps in testicles
- ☐ Other _____

FEMALE
- ☐ Pregnant? _____
- ☐ Total Pregnancies _____
- ☐ Ectopic
- ☐ Miscarriage
- ☐ Cesarean
- ☐ Abnormal Pap Smear
- ☐ Frequent Urinary tract infections
- ☐ Frequent vaginal infections
- ☐ Pain/itching of genitalia
- ☐ Genital lesions / discharge
- ☐ Pelvic inflammatory disease
- ☐ Abnormal Pap Smear
- ☐ Irregular periods
- ☐ Painful menstrual periods
- ☐ Premenstrual syndrome
- ☐ Abnormal bleeding
- ☐ Menopausal syndrome
- ☐ Hot Flashes
- ☐ Other _____

NEUROLOGICAL
- ☐ Seizures
- ☐ Tremors
- ☐ Numbness or tingling of limbs
- ☐ Concussion
- ☐ Pain
- ☐ Paralysis
- ☐ Other_____

PSYCHOLOGICAL
- ☐ Depression
- ☐ Anxiety / Stress
- ☐ Irritability
- ☐ Emotional/psychological issues
- ☐ Other_____

INFECTION SCREENING (+) RESULTS
- ☐ HIV
- ☐ TB
- ☐ Hepatitis
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Syphillis
- ☐ Genital warts
- ☐ Herpes: oral / genital

Patient Name: _____Date: _____

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INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while working or associated with, or serving as a back-up for the acupuncturist named below, including those working at this or any other office, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, exercise therapy Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. 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, mineral, and animal 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 understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

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

By voluntarily signing below I show that I have read, or have had read to me, this 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 condition and for any future condition(s) for which I seek treatment.

Patient name:	Date:
Patient Signature (Patient Representative):	

Patient Name: _____Date: _____

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HEALTH INFORMATION PRIVACY POLICY

Dear Valued Patient,
This notice describes the office's policy for how medical information about you may be used and disclosed and how your privacy is being protected.
In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information in the following cases:

- Payment: In order to secure payment we may disclose health care information to your insurance company or with Worker's Compensation (and your employer as well in this instance)
- Treatment: Your health care information may be disclosed to other healthcare professionals within the practice or other medical practitioners that you authorize
- Emergencies: In the event of an emergency, we may need to notify a family member or other person responsible for your care that you have been in an emergency situation.
- Public Health: As required by law, we may disclose your health information to public health authorities for the purpose of preventing or controlling disease, reporting child or elder abuse or neglect, reporting domestic violence or reporting disease or infectious exposure, for example
- Judicial and Administrative Proceedings or Law Enforcement: For example in the case of complying with a court order or subpoena.
- Other Communication: For example, we may call your home to remind you of an appointment. No protected health information will be provided on this call except for the date and time of your scheduled appointment.

Safeguards in place at our office 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, telephone, and faxes sent) are kept on permanent file.

In administering your health care, we gather and maintain information that may include:

- Non-public personal information
- Information about your financial transactions with us (billing transactions)
- Medical history, treatment notes, medical test results, and any letters, faxes, emails or telephone conversations to or from this office, to or from other health care practitioners, from health care providers, insurance companies, workman's comp and your employer, and other third part administrators (e.g. requests for medical records, claim payment information).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 510.730.0608

Sincerely,
Angela Tsui, Lac.

By signing this document, I acknowledge that I have reviewed or
received a copy of Tsui Acupuncture's Health Information Privacy Policy

Patient name:	Date:
Patient Signature (Patient Representative):	
Please write your email if you would like e-copy of this Health Information Privacy Policy:	

Patient Name: _____Date: _____