HEALING OAK ACUPUNCTURE CLINIC

Acupuncture, Chinese Herbal & Holistic Medicine
Randall Wegener, L. Ac., Dipl. Ac., MSTOM

PERSONAL INFORMATION

Date ______________________________

Patient's Name ____

Patient's Home Address ____

City ____________________________________ State ____ Zip _____________

Home Phone ___________________________ Work Phone _____________________

Cell Phone ___________________________ Email __________________________

Social Security No. ______________________ Driver's License No. ______________

Occupation____

Employer____

Business Address ____

Name of Significant Other ____

Employer ______________________________ Work Phone _____________________

Emergency Contact _______________________ Phone No. _____________________

Person Responsible for Payment (If other than Patient)

Name ____

Mailing Address ____

City _________________________________ State ________ Zip __________

Home Phone __________________________ Work Phone _____________________

Insurance Company ☐ **Workers Compensation** ☐

Company Name ____

Policy or Group No. ______________ Claim or ID No. ____________________________

Contact ____

Telephone number ____

Referred By/How did you hear about this clinic? ___________________________________

Have you received acupuncture therapy before? ☐ Yes ☐ No

When ________________ With whom ______________________________________

Sex: ☐ Male ☐ Female Height _____ Weight ____ Birth date _____________ Age ____

Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Engaged ☐ Partnered

Number of children ____ Ages of children ____________________________________

What are the main health concerns for which you are seeking treatment? (List in order of priority)

Are you currently under care of any other health care provider (physician, chiropractor, therapist, massage therapist, etc.) **Yes** ☐ **No** ☐

If yes, please list providers name, title, condition being treated, how long: (continue on back of page)

What makes your condition better ☐ Heat ☐ Cold ☐ Pressure ☐ Rest ☐ Movement ☐ Other

What makes your condition worse ☐ Heat ☐ Cold ☐ Pressure ☐ Rest ☐ Movement ☐ Other

What other forms of treatment have you sought?

List any other health situations you now have.

List any allergies, food sensitivities or cravings that you have.

List any accidents, surgeries, or hospitalizations (include approximate dates).

List any medications and supplements you are currently taking: (Continue on back of page if necessary)

Medicine	Dosage	Reason	How long	Prescribed by	Date of last Checkup

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much
Coffee/Black tea	☐	☐	________	Tobacco	☐	☐	________
Non-medical drugs	☐	☐	________	Alcohol	☐	☐	________
Water intake	☐	☐	________	Soda pop	☐	☐	________

How do you feel about the following areas of your life?

Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Your Comments
Self	☐	☐	☐	☐	☐	________
Significant Other	☐	☐	☐	☐	☐	________
Family	☐	☐	☐	☐	☐	________
Diet	☐	☐	☐	☐	☐	________
Sex	☐	☐	☐	☐	☐	________
Work	☐	☐	☐	☐	☐	________
Exercise	☐	☐	☐	☐	☐	________
Spirituality	☐	☐	☐	☐	☐	________

PAST MEDICAL HISTORY

Please indicate significant illnesses you or a blood relative (Grandparent, parent, sibling) have had:

Illness	You	Your Relative	Approx. Date	Illness	You	Your Relative	Approx. Date
AIDs/HIV	☐	☐	________	Hepatitis	☐	☐	________
Alcohol/Drug Addiction	☐	☐	________	Measles	☐	☐	________
Allergies	☐	☐	________	Mumps	☐	☐	________
Appendicitis	☐	☐	________	Pace Maker	☐	☐	________
Atherosclerosis	☐	☐	________	Polio	☐	☐	________
Asthma	☐	☐	________	Rheumatic Fever	☐	☐	________
Cancer	☐	☐	________	Seizures	☐	☐	________
Chicken Pox	☐	☐	________	Scarlet Fever	☐	☐	________
COPD	☐	☐	________	Stroke	☐	☐	________
Diabetes	☐	☐	________	Thyroid Disease	☐	☐	________
Epilepsy	☐	☐	________	Thyroid Fever	☐	☐	________
Goiter	☐	☐	________	Tuberculosis	☐	☐	________
Gout	☐	☐	________	Ulcers	☐	☐	________
Heart Disease	☐	☐	________	Whooping cough	☐	☐	________
High Blood Pressure	☐	☐	________	Major Trauma	☐	☐	________

STDs: ☐ Gonorrhea ☐ Syphilis ☐ Chlamydia ☐ Herpes Date ________

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SYMPTOM SURVEY

The following is a list of symptoms that you may or may not ever experience.

Please check all symptoms that you currently have or have had in the past 6 months:

GENERAL SYMPTOMS

☐ Lack of appetite ☐ Excessive appetite ☐ Loose stools or diarrhea
☐ Abdominal pain ☐ Digestive problems/indigestion ☐ Constipation
☐ Vomiting ☐ Belching/burping ☐ Hemorrhoids
☐ Feeling the retention of food in the stomach ☐ Colitis or Diverticulitis
☐ Heartburn/reflux ☐ Dislike weather changes ☐ Chest pain
☐ Difficulty digesting oily foods ☐ Black tarry stool ☐ Blood in stool ☐ Light colored stools
☐ Fatigue ☐ Shortness of breath ☐ Cough
☐ Bronchitis ☐ Decreased sense of smell ☐ Frequent colds
☐ Nasal problems ☐ Hay fever ☐ Skin problems
☐ Recent use of antibiotic ☐ Jaundice (yellowish eyes or skin) ☐ Eye problems
☐ Headaches ☐ Pain or coldness in genital area ☐ Gall stones
☐ Easily angered or agitated ☐ Easily bruised ☐ Sudden weight loss
☐ Difficult to stop bleeding ☐ Difficulty making plans/decisions ☐ Dizziness
☐ Feeling of claustrophobia ☐ High Cholesterol levels ☐ Faint easily
☐ Edema ☐ Soft or brittle nails ☐ Loss of hearing
☐ Ear ringing ☐ Kidney stones ☐ Decreased sex drive
☐ Urinary problems ☐ Hair loss ☐ Cold Hands and Feet
☐ Tendency to become obsessive in work, relationships … ☐ Mental Restless
☐ Laughing for no apparent reason ☐ Heart palpitations
☐ Insomnia difficulty sleeping ☐ Nightmares ☐ Angina pain
☐ Irregular Heart beat

MUSCULOSKELETAL SYMPTOMS

☐ Neck Pain ☐ Upper Back Pain ☐ Lumbar Pain ☐ Shoulder Pain ☐ Elbow Pain
☐ Wrist/Hand Pain ☐ Hip Pain ☐ Knee Pain ☐ Ankle/Foot Pain ☐ Rib Pain
☐ Joint Pain ☐ Sciatic pain ☐ Facial Pain ☐ Dull Pain ☐ Achy Pain ☐ Sharp Pain
☐ Burning Pain ☐ Shooting Pain ☐ Muscle Pain ☐ Muscle Spasms
☐ Severe Pain ☐ Limited Range of Motion
☐ Other ______________________________________

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FOR WOMEN

Age of 1st period (menarche) ______ Are you pregnant? ☐ Yes ☐ No # of pregnancies _____
Age of last period (menopause) ____ # of live births ____ of abortions __ # of miscarriages ___
Number of days between periods ____ Number of days of flow ___ Color of flow __________
Clots? ☐ Yes ☐ No Color ___________
Average number of pads per day: 1st day __ 2nd day __ 3rd day __ 4th day __ + days ____

Date of last: Gynecological exam ______ Pap Smear ______ Mammogram _________
Bone Density Scan ________ Results ___________________________________

Have you ever been diagnosed with: ☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis
☐ Ovarian Cysts ☐ PID Other ____

Location of Menstrual Pain: ☐ Lower Abdomen ☐ Lower Back ☐ Thighs Other _________

Nature of Menstrual Pain
(Please indicate before, during or after menses)
Cramping ________ Stabbing ________
Burning _________ Aching _________
Dull ____________ Bloating ________
Consistent ________ Intermittent ______
Bearing down sensation ________________

Other Symptoms related to menses:
☐ Discharge ☐ Vaginal dryness
☐ Nausea ☐ Constipation
☐ Ravenous appetite ☐ Diarrhea
☐ Poor appetite ☐ Hot flashes
☐ Increased libido ☐ Headaches
☐ Decreased libido ☐ Mood swings
☐ Swollen breasts ☐ Night sweats
☐ Insomnia

FOR MEN

Date of last prostate check up ______________ PSA results ______________________
Manual prostate exam results ____
Lab results ____

Frequency of urination: Daytime __ Nighttime __ **Color of urine**: ☐ Clear ☐ Murky ☐ Odor

Symptoms related to the prostate:
☐ Prostate problems ☐ Delayed stream ☐ Dribbling ☐ Incontinence
☐ Rectal dysfunction ☐ Increased libido ☐ Decreased libido ☐ Retention of urine
☐ Back pain ☐ Premature ejaculation ☐ Impotence ☐ Groin pain
☐ Testicular pain Other ____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I, ____, have read, reviewed, understand and agree to the Notice of Privacy Policies for healthcare services in this clinic.

This clinic has attempted to provide each patient with a Notice of Privacy Policies.

Patients name (Please print) ______________________________________

Patients Signature ____

Date ________________________

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NOTICE OF PRIVACY POLICIES

Our clinic is dedicated to providing healthcare service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:

Information we receive from you.
Information we receive from other health care providers.
Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations.
You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment and healthcare operations.
You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing
This clinic will not use your health information for marketing communications without your written authorization.

This clinic may send birthday cards newsletters and appointment reminder, by calls, postcards or letters.
Please circle one of the following: **Yes** **No**

Disclosure
This clinic may use or disclose your Protected Health Information when required by law.

Patients' Rights

1. Upon written request you have the right to access, review or receive copies of your health 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.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have the right to receive all notices in writing.

If you have questions, complaints or want more information contact this clinic:

Healing Oak Acupuncture Clinic/Randall Wegener, L. Ac.
593 E. Elder Street, Suite A, Fallbrook, CA 92028

760-451-2188 / healingoakacupuncture.com

You can send a written complaint to:

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

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FEES, SERVICE AND HERB PAYMENT AGREEMENT FOR ACUPUNCTURE AND ORIENTAL MEDICINE CARE

TO ALL NEW PATIENTS:

Welcome to our clinic. We hope that you find our clinic and staff pleasant.

CANCELING OR CHANGING APPOINTMENTS:

We will set a specific course of treatment for you. A certain number of treatments in a set amount of time may be required to get the desired results. If you need to change or cancel an appointment, be sure to make up the missed appointment as soon as possible. If for some reason you need to cancel your appointment please call ahead and let us know so that we may accommodate another patient at that time. **A no show, or without cancellation notice 24 hours minimum prior to the scheduled appointment, well result in a clinic visit charge for the visit.**

UPSETS:

We are here to serve you. Please feel free to speak with our office manager about any upsetting matter.

FEES:

The fees charged at this clinic are comparable to those charged by other specialists with similar qualifications in this geographic area. The fees for clinic services are payable at the time of the visit, except in certain cases where arrangements have been made with our clinic. In those cases where payment arrangements have been made with our office and or if your account becomes past due, we reserve the right to access financial charges at an interest rate of 1.5% of outstanding balance per month for every month that an account remains past due, after 30 days.

INSURANCE:

If you are a patient using insurance, **you are responsible for confirming your policy has acupuncture benefits prior to time of visit.** You are also responsible for the co-pay and deductible if owed that has not been met at time of visit. If your insurance company does not pay within 90 days you will be responsible to pay the outstanding balance due, including, but not limited to, unpaid co-pay, deductible owed and remaining clinic visit fee. **You as an insured patient do authorize medical benefit payments to be sent to our clinic directly.**

WORKERS COMPENSATION:

If you are a patient of workers compensation case, it is your responsibility to provide us with an authorization signed by your employer or supervisor authorizing our clinic to provided services to you on your first visit. It is also your responsibility to provide us with the primary doctor's referral, and the name, address and phone number of the worker's compensation carrier prior to first visit.

For your information, some of our fees are as follows. Once again, Fees (deductible and/or co-payments, etc.) for clinic services are payable at the time of the visit.

Clinic Visit (Evaluation & Management) $30 first visit /$20 (if age17 or under)
Includes complete history and examination

Acupuncture (per treatment visit) Age 14 to 64 - $70
Age 65 or older - $60
Birth to age 13 - $50

Herbology/Herbal Formulas/Vitamins As needed
(Will be discussed prior to dispensing)

__________________________________ _______________
Patient's Signature Date

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