*Consultation starts 15 minutes from your check in time*

*ID required*

# Kang Acupuncture & Herbal Medicine Center

**11226 NE 15th Street, Bellevue, WA 98004 TEL: (425) 401-8885**

## Health History Questionnaire

**Date: _____/_____/_____**

| | | | | |
|---|---|---|---|---|
| First Name Last Name | | | Social Security Number ***(not Required)*** | |
| Address Unit # | | City | State | Zip Code |
| Date of Birth | Place of Birth | Marital Status | Gender | Age |
| Home Phone | Work Phone | Cellular Phone | Confidential Voicemails OK? ☐ Yes ☐ No | |
| Email | Employer Name | Occupation | | |
| Family Physician | | Phone | | |
| Emergency Contact Name | Emergency Contact Phone | Have you been treated by acupuncture or oriental medicine? | | |
| How did you hear about us? Or whom we should thank for - referred by: | | | | |

- **What is/are the main problem(s) you would like us to help you with:**

_____

_____

- When did this problem begin? How did this occur? (please be specific)

_____

- To what extent does this problem interfere with your daily activities (work, sleep, sex)?

_____

- Have you tried any treatments prior to today's visit? If yes, please explain:

_____

- Please list all medications and supplements you are taking (including dosage) :

_____

_____

- Medical History (check if any condition applies to you) :
  ☐ Asthma ☐ COPD ☐ Diabetes ☐ High Blood Pressure ☐ Hepatitis ☐ Heart Attack ☐ Cancer: _____
  ☐ Anemia ☐ GERD ☐ Seizures ☐ Stroke ☐ HIV/AIDS ☐ Tuberculosis ☐ Irritable bowel movement
  ☐ Arthritis ☐ Depression ☐ Thyroid Disease ☐ Kidney Disease ☐ Nerve/Muscle Disease
  ☐ Other: _____
- Do you have any medication or any allergic reactions to anything else? ☐ Yes ☐ No
  If Yes, please explain: _____
- Surgeries or hospital stays and their approximate date/year:

_____

- Family Medical History (check): ☐ Diabetes ☐ High Blood Pressure ☐ Cancer:_____ ☐ Heart Disease
  ☐ Others: _____

Please check any symptoms you are experiencing now

## General

- ❑ Chills
- ❑ Fevers
- ❑ Sweat easily
- ❑ Night sweats
- ❑ Localized weakness
- ❑ Bleed or bruise easily
- ❑ Peculiar tastes or smells
- ❑ Strong thirst (cold or hot)
- ❑ Thirst, no desire to drink
- ❑ Fatigue
- ❑ Sudden energy drop
- ❑ Edema
  Where: _____
  _____
- ❑ Poor sleeping
- ❑ Tremors
- ❑ Poor balance
- ❑ Cravings
- ❑ Change in appetite
- ❑ Poor appetite
- ❑ Weight gain
- ❑ Weight loss

## Respiratory

- ❑ Cough
- ❑ Asthma/wheezing
- ❑ Pain with a deep breath
- ❑ Difficulty in breathing when lying down
- ❑ Production of phlegm. What color:
  _____
- ❑ Coughing blood
- ❑ Pneumonia
- ❑ Bronchitis

Other lung problems:

_____

_____

## Cardiovascular

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chest discomfort/pain
- ❑ Heart palpitations
- ❑ Cold hands or feet
- ❑ Swelling of hands
- ❑ Swelling of feet
- ❑ Blood clots
- ❑ Fainting
- ❑ Difficulty in breathing

*Other heart or blood vessel problems:*

_____

_____

## Head, Ears, Nose & Throat

- ❑ Dizziness
- ❑ Migraines
- ❑ Headaches
- ❑ Facial pain
- ❑ Glasses
- ❑ Poor vision
- ❑ Night blindness
- ❑ Blurry vision
- ❑ Color blindness
- ❑ Blind field
- ❑ Spots in front of eyes
- ❑ Eye pain
- ❑ Eye strain
- ❑ Ringing in ears
- ❑ Earaches
- ❑ Discharge from ear
- ❑ Nose bleeds
- ❑ Sinus congestion
- ❑ Nasal drainage
- ❑ Grinding teeth
- ❑ Teeth problems
- ❑ Jaw clicks
- ❑ Concussions
- ❑ Recurrent sore throats
- ❑ Hoarseness
- ❑ Sores on lips or tongue
- ❑ *Other head or neck problems:*

  _____

  _____

## Genital-Urinary

- ❑ Pain on urination
- ❑ Urgency to urinate
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Decrease in flow
- ❑ Unable to hold urine
- ❑ Dribbling
- ❑ Kidney stones
- ❑ Impotency
- ❑ Change of sexual drive
- ❑ Sores on genitals

*Do you wake up to urinate?*
☐ Yes. ☐ No.

**How often?**

_____

*Any particular color in your urine?*

_____

*Other genital or urinary system problems:*

_____

_____

## Skin & Hair

- ❑ Rashes
- ❑ Itching
- ❑ Change in hair or skin
- ❑ Ulcerations
- ❑ Eczema
- ❑ Oozing on skin lesion
- ❑ Hives
- ❑ Pimples
- ❑ Loss of hair

*Other hair or skin problems:*

_____

_____

## Pregnancy & Gynecology

Number of pregnancies: ___
Number of births:_____
Number of premature births: _____
Number of miscarriages: _____
Number of abortions: ___
Age at first menses: ___
Period between menses (days): _____
Duration of menses (days):

_____

First date of last menses:
**_____/_____/___**

- ❑ Heavy periods
- ❑ Light periods
- ❑ Painful periods
- ❑ Irregular periods
- ❑ Changes in body/psyche prior to menstruation
- ❑ Clots
- ❑ Menopause:
  Age _____ Year_____
- ❑ Vaginal discharge

**Do you practice birth control?**
☐☐☐ Yes. ☐ No.

*What type and for how long?*

_____

_____

## Neuro-psychological

- ❑ Seizures
- ❑ Areas of numbness
- ❑ Weakness
- ❑ Sleep disorder
- ❑ Concussion
- ❑ Bad temper
- ❑ Loss of control/violence potential
- ❑ Vertigo
- ❑ Lack of coordination
- ❑ Depression
- ❑ Easily susceptible to stress
- ❑ Loss of balance
- ❑ Poor memory
- ❑ Anxiety
- ❑ Substance abuse

*Have you ever been treated for emotional problems?*
☐ Yes. ☐ No.

*Have you ever considered or attempted suicide?*
☐ Yes. ☐ No.

**Other neurological or psychological problems:**

_____

_____

_____

## Musculoskeletal

- ❑ Neck pain
- ❑ Shoulder pain
- ❑ Back pain
- ❑ Elbow pain
- ❑ Hand/wrist pain
- ❑ Hip pain
- ❑ Knee pain
- ❑ Foot/ankle pain
- ❑ Muscle pain
- ❑ Muscle weakness

**Indicate on diagram on the next page >>>**

Please note the degree of severity of your problem now:

1 2 3 4 5 6 7 8 9 10

No problem Worst Imaginable

Please note the greatest degree of severity of your problem within the last week:

1 2 3 4 5 6 7 8 9 10

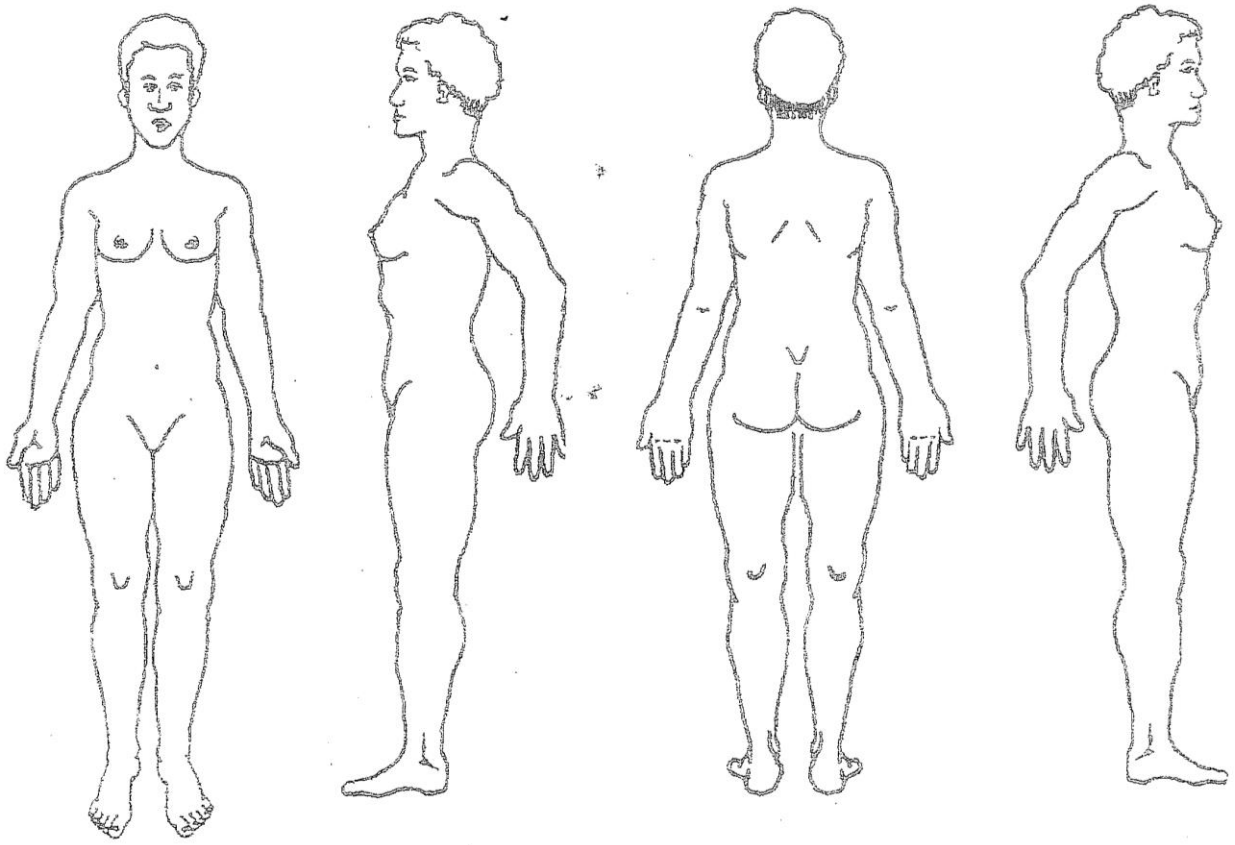
No problem Worst Imaginable

## Indicate painful or distressed areas:

Identify **CURRENT** symptomatic areas in your body by drawing the symbols on the figures below.

KEY:

- ◯ Circle areas of **PAIN**
- X "X" over areas of **JOINT AND MUSCLE STIFFNESS**
- Draw a squiggly lines along the areas of **NUMBNESS OR TINGLING**
- Mark **SCARS, BRUISES** or **OPEN WOUNDS**



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# Patient Notification of Qualifications and Scope of Practice

By law, all East Asian medicine practitioners, including acupuncturists, must provide the below information to patients prior to or at the time of the initial patient visit. RCW 18.06.130 and WAC 246-803-300.

1. Qualifications include the following education and license information:
   - Medical degree in Western medicine from Norman Bethune Medical Science University in Changchun, China;
   - Master of Acupuncture degree from the Northwest Institute of Acupuncture and Oriental Medicine in Seattle, WA;
   - Diplomate in Acupuncture from the National Commission for the Certification of Acupuncturists; and
   - Licensed Acupuncturist in the state of Washington. License No. AC00000391 – issued July 31, 1997.

2. The scope of practice for an East Asian medicine practitioner in the state of Washington includes the following:

   (a) **Acupuncture**, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians;
   (b) Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians;
   (c) **Moxibustion**;
   (d) **Acupressure**;
   (e) **Cupping**;
   (f) **Dermal friction technique**;
   (g) **Infra-red;**
   (h) Sonopuncture;
   (i) Laserpuncture;
   (j) Point injection therapy (aquapuncture); and
   (k) **Dietary advice and health education** based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements;
   (l) **Breathing, relaxation, and East Asian exercise techniques**;
   (m) Qi gong;
   (n) **East Asian massage and Tui na**, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; and
   (o) **Superficial heat and cold therapies**.

3. Side effects may include, but are not limited to:
   (a) Pain following treatment;
   (b) Minor bruising;
   (c) Infection;
   (d) Needle sickness; and
   (e) Broken needle.

- **The patient must inform the East Asian medicine practitioner if the patient has a severe bleeding disorder or pace maker prior to any treatment.**

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## Consent for Treatment

I was provided and have reviewed the **Patient Notification of Qualifications and Scope of Practice.**
(Patient/Representative Initials)_____

I hereby authorize Kang Acupuncture & Herbal Medicine Center including ErKang Hu, a national and Washington state certified acupuncturist, to perform the following specific procedures:

**Acupuncture:** insertion of special sterilized needles through the skin into underlying tissues at specific points on the surface of the body.

**Cupping:** a technique to relieve symptoms in which cups made of glass or other materials are placed on the skin with a vacuum created by heat or other device.

**Plum blossom or seven-star hammer:** a light tapping of an area of the body with a small, sterile hammer that has seven points.

**Gua Sha:** a rubbing on an area of the body with a blunt, round instrument.

**Moxa:** indirect burning on an acupoint using stick, string, or ball moxa to relieve symptoms.

**Tui-na:** an ancient massage used to treat a wide variety of common disharmonies.

**Dietary Advice:** based on traditional Chinese Medical Theory.

**Herbs/Natural Medicines:** prescribing of various therapeutic substances including plant, mineral, or animal materials. Substances may be given in the form of teas, pills, powders, tinctures (may contain alcohol), topical creams, pastes, plasters washes, suppositories or other forms Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.

**Electromagnetic and Thermal Therapies:** includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and infrared and ultraviolet therapies or moxa – warming or indirect burning of an acupuncture point and hydrotherapies.

**I recognize the potential risks and benefits of these procedures as described below:**

**Potential risks:** discomfort, pain, infection, or blistering at the site of the procedure; temporary discoloration of the skin; nausea, loose bowel movements, abdominal cramping; and aggravation of symptoms existing prior to the acupuncture treatment.

**Potential benefits:** drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem and the strengthening of the constitution.

**Notice to Pregnant Women:** Labor-stimulating acupuncture points are not used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment. All female patients must alert the intern or doctor if they know or suspect they are pregnant.

I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Kang Acupuncture & Herbal Medicine Center regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or if it is required or permitted by applicable law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last treatment. I understand that any questions I have will be answered by my practitioner to the best of her ability.

I release ErKang Hu, Kang Acupuncture & Herbal Medicine Center, and employees thereof from any and all liability, which may occur in connection with the above procedures, except for failure to perform the procedures with appropriate medical care.

Printed name of patient: _____

Signature of patient or authorized representative: _____

Printed name of authorized representative (if applicable): _____

Relationship of authorized representative to patient (if applicable): _____

Date: _____

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## Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of the HIPAA Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by contacting:

Kang Acupuncture & Herbal Medicine Center
11226 NE 15th Street
Bellevue, WA 98004
Phone: (425) 401-8885 | Fax: (425) 401-8835

Printed name of patient: _____

Signature of patient or authorized representative: _____

Printed name of authorized representative (if applicable): _____

Relationship of authorized representative to patient (if applicable): _____

Date: _____

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## Financial Agreement

By signing below, I acknowledge my responsibility for payment for the services received from Kang Acupuncture Herbal Medicine Center, in accordance with their regular rates and terms. I understand that I am responsible to pay for charges not covered or paid for by my insurance companies. My responsibility is not modified by whether any third party pays for all, part, or one of the charges. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. Specifically, I understand that my account becomes delinquent if not paid within 30 days of billing. I also understand that I am responsible to pay reasonable attorney's fees and collection expenses should my account be referred to an attorney or agency for collection.

## Cancellation Policy

Kang Acupuncture operates on an appointment basis to allow us to give our patients an appointment when needed and allow the clinic to function efficiently. All appointment once made with the clinic reception will be considered confirmed.

We ask our patients that have scheduled appointments to be mindful that **our clinic requires 24 hours notice to cancel or change an appointment**. This allows us the time required to offer those appointments to other patients in need**. Late cancellation or no shows will result with a $50 fee.**

I HAVE READ AND UNDERSTAND THE ABOVE, ALL PERSONAL AND FINANCIAL INFORMATION THAT I HAVE PROVIDED TO INTEGRATED ORIENTAL MEDICINE, IS TRUE AND ACCURATE.

Printed name of patient: _____

Signature of patient or authorized representative: _____

Printed name of authorized representative (if applicable): _____

Relationship of authorized representative to patient (if applicable): _____

Date: _____