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Baihui Patient Intake Form

Welcome to Baihui Acupuncture, LLC. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. Even though some of the questions may seem unrelated to your condition, they may play a contributing role in diagnosis and treatment. All your information will be confidential and if you have any questions, please ask. Thank you.

Contact Information Today's Date: ____/____/____

Name: _____ Gender: F ☐ M ☐ DOB: ___/___/____ Age: _____

Street:_____ Email: _____

City: _____ State: _____ Zip: _____ Phone: _____

Marital Status: M ☐ S ☐ D ☐ W ☐ # of Children: _____ Alternative Phone: _____

Occupation: _____ Employer: _____

Driver's License Number _____ State _____

Emergency Contact: _____ Phone: _____

How did you find out about us? Direct Mail ☐ Location/Walk By ☐ Friend/Relative ☐ Website ☐

Periodicals ☐ Yellow Pages ☐ Other ☐ _____ Referred By: _____

Have you had acupuncture before? Yes ☐ No ☐ Do you have any of the following? Pacemaker ☐

Insulin Pump ☐ Seizure Disorders ☐ Bleeding Disorders ☐ Pain Analgesic Pump ☐ Pregnant ☐

Implanted Electrical Devices ☐ Nerve Stimulator ☐ Do you bruise easily? Yes ☐ No ☐

Insurance

Primary Insurance Company: _____

Name of Insured_____ ID #: _____ Group # _____

Relationship to Patient: Self ☐ Spouse ☐ Parent ☐ Customer Service Phone: _____

Secondary Insurance Company: _____

Name of Insured_____ ID #: _____ Group # _____

Relationship to Patient: Self ☐ Spouse ☐ Parent ☐ Customer Service Phone: _____

Major Health Complaint(s)

List in the order of importance:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

For each condition listed above, please check if better or worse with:

	HEAT	COLD	REST	ACTIVITY
1.	Better ☐ Worse ☐	Better ☐ Worse ☐	Better ☐ Worse ☐	Better ☐ Worse ☐
2.	Better ☐ Worse ☐	Better ☐ Worse ☐	Better ☐ Worse ☐	Better ☐ Worse ☐
3.	Better ☐ Worse ☐	Better ☐ Worse ☐	Better ☐ Worse ☐	Better ☐ Worse ☐
4.	Better ☐ Worse ☐	Better ☐ Worse ☐	Better ☐ Worse ☐	Better ☐ Worse ☐
5.	Better ☐ Worse ☐	Better ☐ Worse ☐	Better ☐ Worse ☐	Better ☐ Worse ☐
6.	Better ☐ Worse ☐	Better ☐ Worse ☐	Better ☐ Worse ☐	Better ☐ Worse ☐

	MASSAGE	OTHER	PLEASE DESCRIBE
1.	Better ☐ Worse ☐	Better ☐ Worse ☐	_____
2.	Better ☐ Worse ☐	Better ☐ Worse ☐	_____
3.	Better ☐ Worse ☐	Better ☐ Worse ☐	_____
4.	Better ☐ Worse ☐	Better ☐ Worse ☐	_____
5.	Better ☐ Worse ☐	Better ☐ Worse ☐	_____
6.	Better ☐ Worse ☐	Better ☐ Worse ☐	_____

When did the problem begin? _____

What are the participating factors? _____

Have you been given a diagnosis for this problem? Yes ☐ No ☐

If yes, please describe _____

What kind of treatments have you tried? _____

What makes the problem worse? _____

Better? _____

Is there anybody in your family with the same problem? Yes ☐ No ☐

Please describe how these conditions affect or impair your daily activities? Examples may include your overall quality of life, work, family life, hobbies or self-esteem.

_____

_____

Past Medical History

Check any conditions that you have had in the past or are currently experiencing: P=Past C=Current

P	C		P	C	
☐	☐	Alcohol/Drug Abuse	☐	☐	Jaundice
☐	☐	Anemia	☐	☐	Kidney Disease
☐	☐	Arthritis	☐	☐	Liver Disease
☐	☐	Asthma	☐	☐	Mental Illness
☐	☐	Auto Immune	☐	☐	Migraines
☐	☐	Blood Transfusion	☐	☐	Nervous Disorder
☐	☐	Cancer	☐	☐	Pneumonia
☐	☐	Diabetes	☐	☐	Stroke
☐	☐	Digestive Disorder	☐	☐	Thyroid Disorder
☐	☐	Epilepsy/Seizures	☐	☐	Tuberculosis
☐	☐	Heart Disease	☐	☐	Vein Condition
☐	☐	Hepatitis C	☐	☐	Venereal Disease
☐	☐	Heavy Bleeding/Hemorrhage	☐	☐	Other: _____
☐	☐	High Cholesterol			
☐	☐	HIV Hepatitis			
☐	☐	Hypertension			

Known allergies (food, medications or other) _____

Significant trauma (car accident, sports injuries, etc.) _____

Immunizations: _____

Hospitalizations/surgeries (procedures and dates): _____

Dental procedures (include any silver fillings/mercury amalgams) _____

Do you have a history of frequent antibiotic use? Yes ☐ No ☐
Please describe: _____

Allergy shots? Currently ☐ In the past ☐ Never ☐

Please briefly describe your health as a child (e.g. allergies/asthma, prone to illness, etc)

Family Medical History (please specify family member)

☐ Alcoholism/Drug Abuse	☐ Hypertension
☐ Asthma/Allergies	☐ Miscarriage
☐ Cancer	☐ Osteoporosis
☐ Depression/Mental Illness	☐ Stroke
☐ Diabetes	☐ Other _____
☐ Heart Disease	

Current Health & Lifestyle

Do you smoke? Yes ☐ No ☐ If yes, how many per day? _____ For how long? _____
Do you exercise? Yes ☐ No ☐ If yes, how many times per week? _____
Please describe: _____

Do you travel frequently? Yes ☐ No ☐
Have you traveled overseas to 'developing' countries? Yes ☐ No ☐
Do you sit in traffic/commute as a daily routine? Yes ☐ No ☐
Height: _____ Weight: Now _____ One year ago _____ Maximum _____ @ Year _____
How many hours do you sleep in general? _____ When do you usually go to bed? _____

List three things you do currently that support your overall health.

1. _____
2. _____
3. _____

List your three favorite vices (e.g. smoking, social drinking, sweet tooth, etc.)

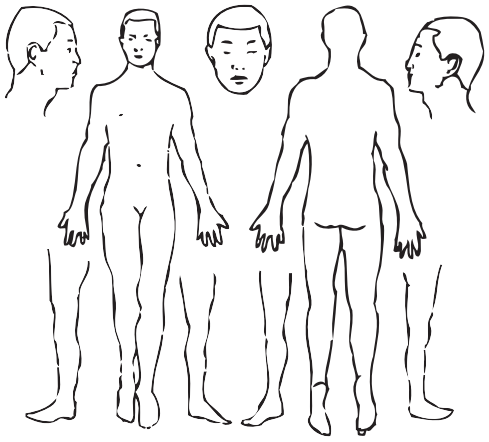
1. _____
2. _____
3. _____

Overall, do you feel that your lifestyle contributes to or takes sway from your health? Yes ☐ No ☐

Diet

Soft drinks per day: _____ Cups of tea per day: _____ Cups of coffee per day: _____
Glasses of water per day_____ Alcoholic beverages per week: _____
Are you a vegetarian? Yes ☐ No ☐ Yes, but not strict ☐ Explain: _____
_____
Please describe your average daily diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Foods you tend to crave: _____

Please indicate painful or distressed areas by using the symbol that best describes the feeling:



Mark with appropriate symbols:

X - Sharp / Stabbing
P - Pins and Needles
D - Dull / Aching
N- Numbness

Please rate your current level of pain: Very mild 1 2 3 4 5 6 7 8 9 10 Very severe

Medications and Supplements

Medications you are currently taking (please include prescription medicines, vitamins, supplements, over the counter drugs, herbal supplements, etc)

_____

_____

Acupuncture and Chinese Medicine focus on the detection and correction of blood circulation problems to maintain proper health. Please carefully complete the following section so that we may have a better understanding of your health status and the stress that your body has previously had or currently is experiencing.

Heart Function

(The following symptoms are indicators of the heart system malfunction. The heart governs the blood and blood vessels, manifests on the complexion, governs the mind, affects speech and taste, opens to the tongue, controls perspiration related to joy. Please check any that you have experienced in the past six months).

☐ Cardiovascular disease	☐ Anxiety	☐ Chest pain
☐ Fainting	☐ Mental Conditions	☐ Wake unrefreshed
☐ Restlessness	☐ Low blood pressure	☐ Restless dreaming/sleep
☐ Nightmares	☐ Sores on tip of tongue	☐ Waking during the night
☐ High blood pressure	☐ Hard to fall asleep	
☐ Palpitations	☐ Dizziness	

Overall Energy

(Blood circulation problems in the lungs and kidneys combined can cause the following problems. Please check any that you have experienced in the past six months).

☐ Difficulty breathing	☐ Shortness of breath	☐ General weakness
☐ Easily catch colds	☐ Low energy	☐ Feel worse after exercise

Lung Function

(The following symptoms are indicators of lung system malfunction. The lungs govern breathing, controls the immune system, regulate water passage, control the skin and open the nose, throat and sinuses. Please check any that you have experienced in the past six months).

- ☐ Profuse nasal discharge
- ☐ Nose bleeds
- ☐ Sore throat
- ☐ Cough – wet or dry
- ☐ Alternating fever and chills
- ☐ Lack of perspiration
- ☐ Stiff shoulders
- ☐ Itching
- ☐ Smoke cigarettes
- ☐ Thin/clear/funny nasal discharge
- ☐ Sinus congestion/sinusitis
- ☐ Bronchitis
- ☐ Allergies to pollen/food/medications
- ☐ Perspire easily
- ☐ Hive
- ☐ Eczema
- ☐ Thick, white nasal discharge
- ☐ Post nasal drip
- ☐ Asthma
- ☐ Sweaty hands
- ☐ Achy body feeling
- ☐ Thick, yellow nasal discharge
- ☐ Excessive dandruff
- ☐ Dry, itchy throat
- ☐ Loss of smell
- ☐ Sweaty feet
- ☐ Stiff neck
- ☐ Rashes
- ☐ Melancholy/sadness
- ☐ Dry skin
- ☐ Sneezing
- ☐ Difficulty inhale/exhale
- ☐ Other _____

Spleen Function

(The following symptoms are indicators of spleen system malfunction. The spleen assists in breaking food down into usable nutrients and then transports those nutrients throughout the body, keeps the blood in the blood vessels, governs the muscles, manifests in the lips and holds the organs up in the body. Please check any that you have experienced in the past six months).

- ☐ Low appetite
- ☐ Abrupt weight loss
- ☐ Fatigue after eating
- ☐ Worry
- ☐ Changes in appetite
- ☐ Abdominal bloating
- ☐ Abdominal bleeding
- ☐ Easily bruised
- ☐ Prolapsed organs
- ☐ Cravings for what _____
- ☐ Abdominal gas
- ☐ Hemorrhoids
- ☐ Abrupt weight gain
- ☐ Stomach gurgling
- ☐ Over thinking
- ☐ Craves sweets

Spleen, Stomach, Large Intestine, Small Intestine Function

(Blood circulation problems in the spleen, stomach, large intestine and small intestine combined can cause the following problems. Please check any that you have experienced in the past six months).

- ☐ Loose stools
- ☐ Diarrhea
- ☐ Mucous in stools
- ☐ Incomplete bowel movements
- ☐ Blood in stools
- ☐ Black/tarry stools
- ☐ Constipation
- ☐ Undigested food in stools
- ☐ Acne
- ☐ Chronic use of laxatives; what type of laxatives? _____

Dampness/Mucous Trapped in Body

(The following symptoms are indicators of "dampness/mucous," which simply refers to fluids that are not metabolized effectively and cause health problems in the body. Please check any you have experienced in the past six months).

- ☐ Swollen joints
- ☐ Swollen hands
- ☐ General sensation body heaviness
- ☐ Swollen feet
- ☐ Swollen legs
- ☐ Head, sinus, ear congestion
- ☐ Snoring
- ☐ Pain or symptoms worse in damp/rainy weather
- ☐ Swollen arms
- ☐ Chest congestion

Stomach Function

(The following symptoms are indicators of stomach malfunction. The stomach controls the breakdown of food and nutrients, descends the energy and is the origin of body fluids. Please check any you have experienced in the past six months).

- ☐ Burning sensation after eating
- ☐ Sores on lips, tongue or mouth
- ☐ Cold sensation in stomach
- ☐ Bleeding, swollen or painful gums
- ☐ Excessive appetite
- ☐ Ulcer
- ☐ Hiccoughs
- ☐ Acne
- ☐ Bad breath
- ☐ Belching
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Acid regurgitation
- ☐ Heartburn

Liver and Gallbladder Function

(The following symptoms are indicators of liver and gallbladder system malfunction. The liver stores blood, ensures blood, body fluids and energy circulation throughout the body, nourishes the tendons and ligaments, reflects on the nails and opens in the eyes, closely related to anger and tears. The gallbladder stores bile, which breaks down fat. Please check any you have experienced in the past six months).

- ☐ Chest pains
- ☐ Tight sensation in chest
- ☐ Bitter taste
- ☐ Anger easily, irritability
- ☐ Frustration
- ☐ Depression
- ☐ Anxiety
- ☐ Teeth grinding
- ☐ Tingling sensations
- ☐ Numbness
- ☐ Muscle spasms, twitching
- ☐ Muscle cramping
- ☐ Seizures, convulsions
- ☐ Genital sores
- ☐ Skin rashes
- ☐ Alternating diarrhea and constipation
- ☐ Neck tension
- ☐ Shoulder tension
- ☐ Hip pain, Sciatica
- ☐ Drink alcohol
- ☐ Gallstones
- ☐ Sensation of lump in throat
- ☐ Recreational drug use
- ☐ Migraines
- ☐ Headaches (temple, sides, top)
- ☐ High pitch ringing in ears
- ☐ Frequently unable to adapt to stress (causes)? _____

Eyes (Liver Function)

(Blood circulation problems in the liver and can cause the following eye problems. Please check any that you have experienced in the past six month).

- ☐ Itchy
- ☐ Watery
- ☐ Near-sighted
- ☐ Red or bloodshot
- ☐ Gritty or sandy feeling
- ☐ See floaters, floating black spots in the eyes
- ☐ Far-sighted
- ☐ Hot
- ☐ Blurry vision
- ☐ Cataracts
- ☐ Other eye problems _____
- ☐ Decreased night vision
- ☐ Visual disturbances
- ☐ Dry

Kidney Function

(The following symptoms are indicators of kidney system malfunction. The kidney and adrenal system governs birth/growth/reproduction/development, produce the bone marrow, nourish the brain, control the bones, governs water, opens to the ears, manifests in the hair, controls the urethra, spermatic duct and lower section of the large intestines. Please check any that you have experienced in the past six months).

- ☐ Frequent cavities
- ☐ Low pitch ringing in the ears
- ☐ Low back pain
- ☐ Excessive hair loss
- ☐ Bladder, urinary tract infections
- ☐ Hot body temperature, sensation
- ☐ Heat in the palms, soles & chest
- ☐ Weak knees
- ☐ Painful knees
- ☐ Hot flashes any time of the day
- ☐ Strong thirst, if yes, do you thirst for hot or cold drinks? _____
- ☐ Easily broken bones
- ☐ Poor hearing
- ☐ Foot weakness, pain
- ☐ Pre-mature grey hair
- ☐ Sneeze, jump incontinence
- ☐ Afternoon flushes
- ☐ Cold body temp sensation
- ☐ Ankle weakness, pain
- ☐ Lack of bladder control
- ☐ Hair loss
- ☐ Fear
- ☐ Night sweats
- ☐ Cold feet
- ☐ Earaches
- ☐ Cold in knees
- ☐ Memory problems
- ☐ Kidney stones
- ☐ Easily startled
- ☐ Cold hands

Urination

(The following symptoms are indicators of urinary bladder system malfunction. The urinary bladder stores and eliminates impure fluids from the body. Please check any that you have experienced in the past six months).

How many times per day do you urinate? _____

Do you wake during the night to urinate? Yes ☐ No ☐ If yes, how many times per night? _____

- ☐ Dark yellow
- ☐ Scanty
- ☐ Painful
- ☐ Clear
- ☐ Yellow
- ☐ Profuse, excessive
- ☐ Difficult, straining
- ☐ Reddish
- ☐ Strong odor
- ☐ Urgency
- ☐ Cloudy
- ☐ Burning
- ☐ Incomplete urination

Libido

(Blood circulation problems to the genitals can cause problems. Libido is a sign of overall health and vitality).

Is your libido ☐ Low ☐ Normal ☐ Too high

Men Only:

(Blood circulation problems to the male genitals can cause the following function problems. Please check any that you have experienced).

☐ Swollen testes ☐ Premature ejaculation
☐ Impotence ☐ Other _____
☐ Testicular pain
☐ Feeling of coldness or numbness in external genitalia

Women Only:

Do you currently, or have you ever used any birth control/IUD? ☐ Yes ☐ No If yes, please list types and dates of use: _____
How often do you experience vaginal discharge? _____
Do you experience any odor with the discharge? ☐ Yes ☐ No
What is the length of you menstrual cycle (ex: 26-30 days)? _____
What is the start date of you last period? _____
On average, how many days do you bleed during your period? _____
Do you experience any uterine bleeding outside of menses, or spotting between periods? ☐ Yes ☐ No
If yes, how much and how often? _____
What was the age of your first menstrual cycle? _____
What was the age of menopause onset (if applicable)? _____
Number of pregnancies: _____ Number of live births: _____
Number of miscarriages: _____ What term miscarriage? _____

Blood circulation problems in the uterus can cause the following menstrual problems. Do you experience any of the following pre-menstrual syndromes?

☐ Nausea ☐ Headaches ☐ Anxiety
☐ Food cravings ☐ Irritability ☐ Breast swelling
☐ Depression ☐ Water retention ☐ Breast tenderness
☐ Vomiting ☐ Migraines ☐ Acne
☐ Sharp pain, where? _____
☐ Dull pain, where? _____
☐ Other: _____

Tongue

Body Color

☐ Pale ☐ Red ☐ Deep red ☐ Purple

Body Form

☐ Swollen ☐ Thin ☐ Cracked ☐ Thorny
☐ Flaccid ☐ Rigid ☐ Deviated

Coating Color

☐ Thin and white ☐ Thick and white ☐ Yellow ☐ Grey
☐ Grey, yellowish and dry ☐ Grey, whitish and moist ☐ Black ☐ Orange
☐ No Coating ☐ Brown

Coating Quality

☐ Thin ☐ Thick ☐ Dry
☐ Excessive moisture ☐ No coating ☐ Brown
☐ Mirror, glossy (entirely peeled)
☐ Geographic (partially peeled)
☐ Granular (coarse and soybean curds, easily scrubbed, Patsy)
☐ Sticky (hard to scrub, greasy)

Pulse

Left

☐ Floating ☐ Deep ☐ Slow ☐ Rapid ☐ Empty ☐ Full
☐ Overflowing ☐ Fine/thin ☐ Slippery ☐ Choppy ☐ Wiry ☐ Tight
☐ Soft ☐ Weak ☐ Hasty ☐ Knotted ☐ Intermittent

Right

☐ Floating ☐ Deep ☐ Slow ☐ Rapid ☐ Empty ☐ Full
☐ Overflowing ☐ Fine/thin ☐ Slippery ☐ Choppy ☐ Wiry
☐ Tight ☐ Soft ☐ Weak ☐ Hasty ☐ Knotted ☐ Intermittent

Baihui Acupuncture, LLC - Request & Consent of Treatment

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named, for whom I am legally responsible) by Baihui who now or in the future treat me while employed by, working or associated with Baihui, including those working at Baihui or any other office or clinic, whether signatories to this form or not.

I understand methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Acupressure (Chinese massage) and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify Diane M. Morgan, Acupuncturist, of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally 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. 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. Burns and/or scarring are a potential risk of moxibustion and cupping. 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. 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 Diane Morgan, Acupuncturist, who is caring for me instead of staff.

I understand that no acupuncturist can or should guarantee any "cure" for any course of treatment and that no results can be guaranteed. I also understand that the success of the plan is dependent upon keeping my appointments, following my acupuncturist's instructions and communicating with my acupuncturist about my case, care and treatment.

Patient Signature: _____ Date: _____

Baihui Acupuncture, LLC - New Patient Information

For All Clinic Appointments:
Welcome to Baihui Acupuncture, LLC. Please read our office policies and sign below.

Cancellation Policy: Treatments are by appointment, walk-ins are not accepted and appointments must be made in advance. We do not treat children. If you find that you need to cancel an appointment, it is important that we receive 24-hour notice. This enables us to fill the time slot. **We reserve the right to charge a fee equal to the cost of a scheduled appointment for an appointment canceled with less than 24-hour notice or for a "no show" appointment.**

Payment for Clinic Service Rendered: Payment is due at the time of services and may be paid by cash, check or all major credit cards. Any checks returned due to insufficient funds will be charged an additional $30 by this clinic. We do not accept insurance but will give you a printed receipt with the current CPT codes listed so you may directly submit services rendered for possible reimbursement. You are responsible for payment in full at the time of service.

After Treatment Herbal Prescriptions: All herb sales are final. Baihui Acupuncture and Herbal Medicine are not able to offer refunds on herbal products. Herbal prescriptions are intended only for the patient for whom they have been prescribed.

Thank you for allowing us to provide you with quality healthcare.

Patient Signature: _____ Date: _____

HIPPA DOES NOT require that you give your healthcare provider written permission to share or discuss your health information with your family members, friends or others involved in your care or payment for your care.

If there is a family member, friend or others involved in your care or payment for your care whom you DO NOT want us to share or discuss your health information, you MUST submit in writing to our office a list of those individuals.

Patients/Guardian's Printed Name: _____

Patients/Guardian's Signature: _____ Date: _____

BAIHUI Acupuncture, LLC

233C Oil Well Road, Jackson, TN 38305

Notice of Privacy Practices – Acknowledgement and Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your protected Health Information will be used by Baihui Acupuncture, LLC or may be disclosed to others for the purposes of treatment, obtain payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the front desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____

Patient or Legally Authorized Individual Signature Date

_____ _____

Print Patient's Full Name Date

_____ _____

Witness Signature Date