



Ding's Acupuncture, Massage & Herbs
14042 NE 8th Street, Suite 210
Bellevue, WA 98007

Phone: 425-298-3819; Email: info@DingsAcupuncture.com

PATIENT INFORMATION

Patient:

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: ____ / ____ / ____ Age: ____ SS#: _____

Gender: M / F; Marital Status: Single / Married / Divorced/Other; Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Cell Phone #: _____ Home/ Work Phone #: _____

Email Address: _____

How did you hear about us? _____

Payment Method Cash Check Visa MasterCard Insurance PIP

Insurance Information:

Is it related a motor vehicle accident? Y/N; Date of the accident: _____

Phone# & Name of Adjuster: _____

Name and Phone# Primary Insurance Company: _____

Name & Date of Birth of the Insured: _____

Relationship to Patient: _____ ID / Policy # / Claim #: _____ Group No. _____

Name & Phone# of Secondary Insurance _____

Name & Date of Birth of the Insured: _____ Relationship to Patient _____

Name & Phone# of Your Primary Care Doctor: _____

Emergency Contact:

Name & Phone#: _____ Phone #: _____

Have you been treated by acupuncture or herbals medicine before? Yes: ____ No: ____

The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account. If insurance is billed, I authorize my insurance benefits to be paid directly to Ding's Acupuncture, Massage & Herbs. I understand a 24-hour advance cancellation notice is required. I also authorize Ding's Acupuncture, Massage & Herbs or insurance billing company to release any information including diagnosis and the record of treatment or examinations rendered to me during the period of such medical care required to process my claims.

X _____
Signature of Patient or Parent/Legal Guardian

Date: _____



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Please Put M for Yourself and F for Family with Any Symptoms You or Your Family Had:

General:

- Chills/Fever
- Localized Weakness
- Lack of Thirst
- Tremors
- Bleed or Bruise Easily
- Fatigue
- Poor Balance
- Sweat Easily
- Peculiar Tastes or Smells
- Sudden Energy Drop
- Time of Day _____
- Edema: Where _____
- Night Sweats
- Strong Thirst (Hot/Cold)
- Poor Sleep
- Cravings
- Change in Appetite
- Weight Gain/Loss
- Poor Appetite
- Diabetes, Type I or II
- Cancer
- Hyperthyroidism
- Hypothyroidism
- Hypoglycemia
- Anemia
- Gout
- Osteoporosis/Osteopenia
- Chronic Fatigue Syndrome

Skin and Hair:

- Rashes
- Itching
- Change in Hair or Skin
- Ulcerations
- Eczema
- Oozing on Skin Lesion
- Hives
- Pimples
- Recent Moles
- Loss of Hair
- Dandruff

Head, Eyes, Ears, Nose and Throat:

- Dizziness
- Migraines
- Headaches
- When _____
- Where _____
- Facial Pain
- Glasses
- Poor Vision
- Night Blindness
- Blurry Vision
- Color Blindness
- Floaters in Eyes
- Excessive Tears
- Discharge from Eyes
- Poor Hearing
- 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/Neck Problems
- Allergies

Cardiovascular:

- High Blood Pressure
- Low Blood Pressure
- Chest Discomfort/Pain
- Heart Palpitations
- Cold Hands/ Feet
- Swelling of Hands/Feet
- Fainting

Pregnancy and Gynecology (Women Only):

- Number of Pregnancies
- Number of Births
- Number of Premature Births
- Number of Miscarriages
- Number of Abortions
- Age at First Menses
- # of Days Between Menses
- Days of bleeding
- First Date of Last Menses
- Heavy Periods
- Light Periods
- Painful Periods
- Irregular Periods
- PMS
- Clots
- Menopause
- Age _____
- Year _____
- Vaginal Discharge: color _____
- Post-coital Bleeding
- Vaginal Sores/Dryness
- Date, result of Last PAP _____
- Breast Lumps
- Nipple Discharge
- Do you practice birth control?
 What Type _____
 How long have you practiced
 your current form of birth control?

Respiratory:

- Cough
- Asthma/Wheezing
- Pain with Deep Breath
- Difficulty Breathing Lying
 Down
- Production of Phlegm
 Color _____

Gastrointestinal:

- _____ Bad Breath
- _____ Nausea/Vomiting
- _____ Heartburn/Acid Reflex
- _____ Belching
- _____ Indigestion
- _____ Diarrhea
- _____ Constipation
- _____ Chronic Laxative Use
- _____ Blood in Stools
- _____ Black Stools
- _____ Abdominal Pain/Cramps
- _____ Gas
- _____ Rectal Pain
- _____ Hemorrhoids
- _____ Hepatitis A, B, C
- _____ Gall Bladder Disease
- _____ Ulcers

Genito-Urinary:

- _____ Painful Urination:
- _____ Urgency to Urinate
- _____ Frequent Urination
- _____ Blood/Protein in Urine
- _____ Decrease in Flow
- _____ Urinary Tract Infection
- _____ Dribbling
- _____ Kidney Stones
- _____ Impotency
- _____ Change of Sexual Drive
- _____ Sores on Genitals
- _____ Do you wake up to urinate at night? How many times _____
- _____ Prostate Problems
- _____ Sexually Transmitted Disease: _____

Cardiovascular:

- _____ Blood Clots
- _____ Difficulty Breathing
- _____ Heart Disease
- _____ Stroke
- _____ Heart Murmurs
- _____ Varicose Vein

Neuropsychological:

- _____ Seizures
- _____ Areas of Numbness
- _____ Weakness
- _____ Sleep Disorder
- _____ Concussion
- _____ Bad Temper
- _____ Loss of Control/Violence Potential
- _____ Vertigo
- _____ Lack of Coordination
- _____ Depression
- _____ Easily Stressed
- _____ Loss of Balance
- _____ Poor Memory
- _____ Anger
- _____ Anxiety
- _____ Irritability
- _____ Restlessness
- _____ Tearful
- _____ Mood Swings
- _____ Dementia
- _____ Alzheimer's
- _____ Substance Abuse
- _____ Have you ever been treated for emotional problems? Y/N. When _____
- _____ Have you ever considered or attempted suicide? Y/N. When _____

Respiratory:

- _____ Coughing Blood
- _____ Pneumonia
- _____ Bronchitis
- _____ Other Lung Problems
- _____ Frequent Common Cold

Musculoskeletal:

- _____ Neck Pain
- _____ Shoulder Pain
- _____ Back Pain
- _____ Elbow Pain
- _____ Hand/Wrist Pain
- _____ Hip Pain
- _____ Knee Pain
- _____ Leg/Foot/Ankle Pain
- _____ Muscle Pain
- _____ Muscle Weakness
- _____ Arthritis Pain: Where _____
- _____ MS

Are you pregnant? Y/N

Do you have any autoimmune disease? Y/N. What? _____

Have you been exposed to toxic Chemical, radiation or pesticides? Y/N. What _____

Do you have bleeding disorders? Y/N

Do you have a pacemaker or metal implant? Y/N

Are you taking any blood thinning medication? Y/N. What? _____

Do you have AIDs? Are you HIV+?

Previous Surgeries and Hospitalization (type and date): _____

Significant Trauma or Disease (auto accidents, childhood disease or trauma, falls, etc.): _____



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Current Health Information:

What is/are the main problem(s) you would like us to help you with? When did it/they start?

1. _____ 2. _____
_____ 3. _____

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

_____ Have you been given a
diagnosis for this problem? If so, what?

What kinds of treatment have you tried? _____

Medicine, herbs or supplements taken within last three months and the purposes of taking them:

Allergies (drug, chemicals, foods):

Are you taking or have you taken any non-medical drugs? If yes, describe briefly.

Do you have a regular exercise program? Yes / No If yes, describe briefly:

How much coffee, tea, soft drinks and alcohol do you drink per day or week?

Do/did you smoke? Yes / No. If you quitted smoking, when? _____

Do you eat at least three regular meals a day? Y/N. Describe briefly your typical breakfast, lunch and dinner:

How many ___ hours of sleep do you have a night? Do you wake up feeling refreshed? Yes/No.

How many _____ times bowl movements do you have a day?



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INFORMED CONSENT FOR ACUPUNCTURE

This disclosure is to advise you of the credentials of practitioner, the scope of practice for Acupuncture in the state of Washington and to document your consent for services (WAC 246-802-120)

Credentials: Lei Ding, EAMP, L.Ac, LMP received her master's degree in acupuncture from Bastyr University. She is currently licensed to practice in the State of Washington. She is the owner/manager director of Ding's Acupuncture, Massage & Herbs. She uses safe, effective and holistic healing methods to treat patients. She specialized in pain management, allergies, women's health, and stress/anxiety reduction.

I, _____ (Print Full Name) hereby request and consent to the performance of procedures which are within the scope of the practice of acupuncture and herbal medicine including, but not limited to, acupuncture, acupressure, electroacupuncture, moxabustion, cupping, infrared heat, herbology and dietary advice on me (or on the patient named above, for whom I am legally responsible) by acupuncturist(s) at Ding's Acupuncture, Massage & Herb who now or in the future treat me while employed by, working or associated with or serving as back-up for the clinic named above whether signatories to this form or not.

I have had an opportunity to discuss with the acupuncturist at Ding's Acupuncture, Massage & Herbs, the nature and purpose of acupuncture, acupressure, electroacupuncture, moxabustion, cupping, herbology, dietary advice and other procedures. I recognize the potential benefits of these procedures including drugless relief of presenting symptoms and improved balance of body energies that may lead to the prevention, improvement or elimination of the presenting problems. I also understand and am informed that there are some risks to acupuncture and eastern Asian medicine treatment, including, but not limited to, discomfort, pain, slight bruising, broken needle, fainting, tingling or discoloration of the skin near the needling sites that last a few days, nausea, infection, scarring, blisters and possible aggravation of symptoms existing prior to the acupuncture treatment. If I suspect I am pregnant, I will immediately inform the acupuncturist. If I experience any gastro-intestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. With this knowledge, I voluntarily consent to the above procedures. I hereby release the acupuncturist(s) at or working for Ding's Acupuncture, Massage & Herbs from any and all liabilities, which may occur in connection with the above-mentioned procedures. I intent this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatments. I understand I am free to withdraw this consent and to discontinue participation in these procedures at any time.

Patient with severe bleeding disorders, hepatitis, pacemaker, HIV positive, AIDs, as well as pregnant patients should inform the practitioner prior to receiving treatment.

Name of Patient (print): _____

Or Parent/Guardian

Signature: _____ Date: _____



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INFORMED CONSENT FOR MASSAGE

I understand that the massages given to me by the licensed massage practitioners at Ding's Acupuncture, Massage & Herbs is for the purpose of general relaxation, stress reduction, pain relief from muscle tension or improvement of circulation. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental condition and that no conversations or statements made during or relating to our sessions should be construed as such. The massage therapist neither prescribes medical or pharmaceutical treatment nor performs any spinal adjustments. It has been made clear to me that professional massage therapy is not a substitute for medical or chiropractic treatment. I understand that it is recommended that I see a physician to verify that there is no medical reason that I should not undergo massage therapy and for any physical ailment that I might have. I acknowledge that any sexual or implied sexual comments or actions on my part will result in immediate termination of the massage session and I will be responsible for any and all charges in full. I understand that I will be held responsible in full for any missed appointments without prior notice or for any cancellations made less than 24 hours in advance.

RESULT: The results of massage therapy depends on many variables; such as the status of your condition (acute or chronic), how traumatic is your condition, and your overall health. You should notice some improvement with five to six treatments into your care. In most cases there is a more gradual, but quite satisfactory response.

RETRACING: On rare occasion, especially when your body is fragile, retracing occurs before "true" healing can take place. Retracing is the release and healing of unresolved problems. Patients may report of having "cleansing" symptoms such as diarrhea, pus, mucus, headache, generalized ache and pain, fever, etc. as toxins leave the body. It is very important, especially at this time, to maintain regular treatment schedule to facilitate the healing process.

I have read and understand the above statement. I have stated all of my known medical conditions on the patient history form. I take it upon myself to keep the massage therapist updated on my current health.

Patient with severe bone and bleeding disorders, hepatitis, pacemaker, HIV positive, AIDs, as well as pregnant patients should inform the practitioner prior to receiving treatment.

Name of Patient (print): _____

Or Parent/Guardian

Signature: _____

Date: _____



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NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGMENT

Ding's Acupuncture, Massage & Herbs respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless required by law. We keep a record of the health care services we provide you. You may ask to see a copy of that record. You may also ask to correct that record. You may see your record or get more information about it by contacting the manager of this clinic. Our Notice of Privacy Practices describes in more details how your health information may be used and disclosed, and how you can access your information.

Name of Patient (print): _____
Or Parent/Guardian

Signature: _____ Date: _____

MEDICAL RELEASE TO INSURANCE COMPANY OR OTHER PARTIES

I authorize Ding's Acupuncture, Massage & Herbs or their billing company to release of my medical information to my insurance company/companies, lawyers including diagnosis and the record of treatment or examinations rendered to me during the period of such medical care. I also request insurance company / companies to pay directly to Ding's Acupuncture, Massage & Herbs for those medical services.

Name of Patient (print): _____
Or Parent/Guardian

Signature: _____ Date: _____

Clinical Verification of Signatures Date _____

This form will be retained in your Medical Record.



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FINANCIAL AGREEMENT

I _____ (patient or guarantor) understand that I am financially responsible for all charges whether or not paid by my insurance. I am aware that some and perhaps all of the services provided may be non-covered services under my insurance. I am also aware that verification of insurance benefits is not a guarantee of payment. I also understand that a monthly interest rate of 1.5% will be applied to any unpaid patient balance over 30 days past due.

Name of Patient (print): _____
Or Parent/Guardian

Signature: _____ Date: _____

AGREEMENT BY THE PATIENT REGARDING CANCELLED/MISSED APPOINTMENTS

Patient understands that a missed appointment (No Show) will result in full charges being issued for that appointment. Patients arriving later than 20 minutes past the appointment time are not guaranteed their appointment time slot, and will be charged for the appointment in full. If a patient gives the clinic less than 24 hours notice for the cancellation of appointment, the patient will be charged a \$50. If less than 24 hours notice was given in change of another appointment (which will be within 48 hours), only \$25 will be charged to the patient.

Name of Patient (print): _____
Or Parent/Guardian

Signature: _____ Date: _____



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Pain Location Chart

Mark the areas of pain on diagram with symbols.

Symbols:

Aching

▲▲▲

Numbness

Pin/Needles

ooo

Burning

////

Cold

\\\\\\

Stabbing

^^^

Colic

==

Heavy

###

Pulling

<>

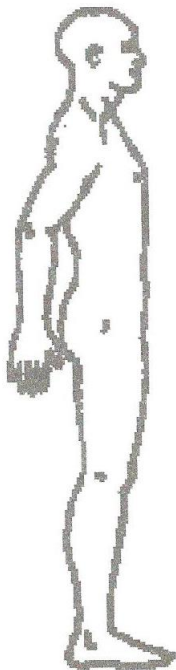
Spasm

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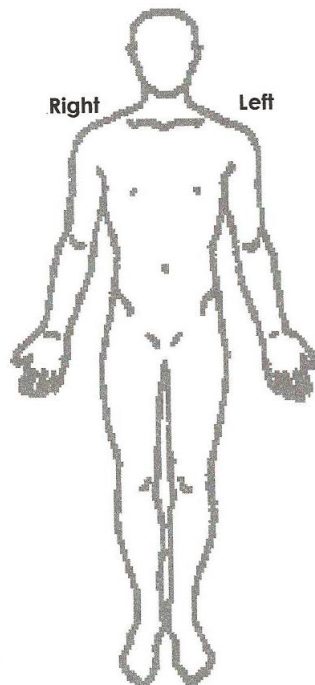
Other

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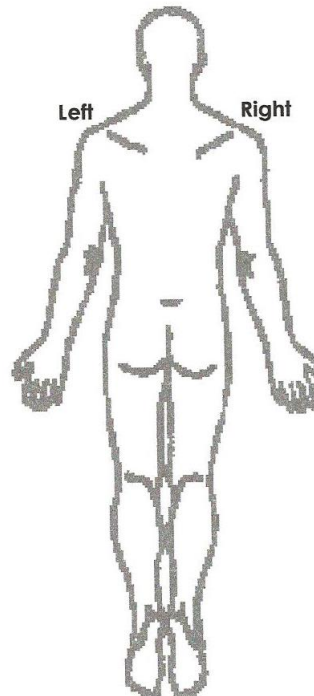
Right



Front



Back



Left

