



Ding's Acupuncture and Wellness
 15446 Bel-Red Road, Suite 405 Redmond, WA 98052
 Tel. (425) 298-3819
 E-mail: dingsacupuncture@gmail.com
 Website: www.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
> <

Other
...

