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 Contract:
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_____ Date: _____
Signature of Patient or Parent/Legal Guardian

Ding's Acupuncture, Massage & Herbs
14042 NE 8th Street, Suite 210
Bellevue, WA 98007
Phone: 425-298-3819; Email: Info@DingsAcupuncture.com

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.): __

_____

Ding's Acupuncture, Massage & Herbs
14042 NE 8th Street, Suite 210
Bellevue, WA 98007
Phone: 425-298-3819; Email: Info@DingsAcupuncture.com

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?

Ding's Acupuncture, Massage & Herbs
14042 NE 8th Street, Suite 210
Bellevue, WA 98007
Phone: 425-298-3819; Email: Info@DingsAcupuncture.com

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: _____

Ding's Acupuncture, Massage & Herbs
14042 NE 8th Street, Suite 210
Bellevue, WA 98007
Phone: 425-298-3819; Email: DingsAcupunctur2@gmail.com

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: _____

Ding's Acupuncture, Massage & Herbs
14042 NE 8th Street, Suite 210
Bellevue, WA 98007
Phone: 425-298-3819; Email: Info@DingsAcupuncture.com

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.

Ding's Acupuncture, Massage & Herbs
14042 NE 8th Street, Suite 210
Bellevue, WA 98007
Phone: 425-298-3819; Email: Info@DingsAcupuncture.com

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: _____

Ding's Acupuncture, Massage & Herbs
14042 NE 8th Street, Suite 210
Bellevue, WA 98007
Phone: 425-298-3819; Email: Info@DingsAcupuncture.com

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 •••