

All Under Heaven Acupuncture & Oriental Medicine
Epic Med Spa
PATIENT REGISTRATION FORM
(Please Print)

Today's date:		PCP:	
PATIENT INFORMATION			
Patient's last name:		First:	Middle:
		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.
Marital status (circle one) Single / Mar / Div / Sep / Wid			
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):	Birth date: / /
			Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:		Home phone no.: ()	Alternate Phone no.: ()
P.O. box:	City:	State:	ZIP Code:
Occupation:	Employer:	Employer phone no.: ()	
Chose clinic because/Referred to clinic by (please check one box):		<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other
Other family members seen here:			

INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
While acupuncture is often not covered by many insurance companies, several companies have begun to offer coverage for acupuncture services. In order to make treatments more affordable and accessible to you, your insurance company will always be contacted to see if your plan offers coverage for acupuncture, should you choose to provide coverage information.			
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ()
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Occupation:	Employer:	Employer address:	Employer phone no.: ()
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please indicate primary insurance			
Subscriber's name:	Birth date: / /	Group no.:	Policy no.: Co-payment: \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize All Under Heaven Acupuncture and Oriental Medicine, Epic Med Spa and my insurance company to release any information required to process my claims.			
_____ <i>Patient/Guardian signature</i>		_____ <i>Date</i>	

ALLERGIES TO MEDICATIONS	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)			
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	Are you dieting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, are you on a physician prescribed medical diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	# of meals you eat in an average day?			
	Rank salt intake	<input type="checkbox"/> High	<input type="checkbox"/> Med	<input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> High	<input type="checkbox"/> Med	<input type="checkbox"/> Low
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you drink?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Have you considered stopping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Have you ever experienced blackouts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Are you prone to "binge" drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Do you drive after drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit		
Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If not trying for a pregnancy list contraceptive or barrier method used:			
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER			Children	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
MOTHER				<input type="checkbox"/> M	
Sibling	<input type="checkbox"/> M		Grandmother Maternal	<input type="checkbox"/> F	
	<input type="checkbox"/> F			<input type="checkbox"/> M	
	<input type="checkbox"/> M			<input type="checkbox"/> F	
	<input type="checkbox"/> F			<input type="checkbox"/> M	
	<input type="checkbox"/> M			<input type="checkbox"/> F	
	<input type="checkbox"/> F				
	<input type="checkbox"/> M			Grandfather Maternal	
	<input type="checkbox"/> F			Grandmother Paternal	
<input type="checkbox"/> M		Grandfather Paternal			
<input type="checkbox"/> F					

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times _____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

All Under Heaven Acupuncture & Oriental Medicine Epic Med Spa

14999 W. Beloit Rd. New Berlin, WI 53151 (414) 529-8400

Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from licensed acupuncturists with All Under Heaven Acupuncture and Oriental Medicine. I understand that acupuncturists practicing in the state of Wisconsin are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioner.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, infection, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. I have informed my practitioner of all substances to which I have had allergic reactions.

Chinese Massage, Acupressure, Guasha, Cupping Therapy, TDP Mineral Wave Lamp, Moxibustion, Magnet Therapy, Ear Seeds: I understand that I may be given the aforementioned therapies as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: local bruising, redness, minor burns, infection, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Chinese Nutrition Therapy: I understand that my practitioner is not a licensed dietitian and is providing dietary guidance based on Chinese medicine principles of nutrition. I understand that I need to immediately consult with my practitioner if I feel I am experiencing effects from these dietary recommendations.

Should I experience any problems, which I associate with any of the treatments described above, I should call All Under Heaven Acupuncture and Oriental Medicine as soon as possible. In case of a medical emergency, I should seek immediate medical care at the hospital emergency room.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I have read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask the practitioner for a more detailed explanation.

PRINTED NAME

SIGNATURE

DATE

ADDRESS

All Under Heaven Acupuncture and Oriental Medicine LLC at Epic Med Spa

14999 W. Beloit Rd. New Berlin, WI 53151
(414) 529-8400

Notice of Privacy Practices

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Information that we use or disclose based on the authorization you are giving us may be subject to redisclosure by the person who receives the information and may no longer be protected by the federal privacy rules.

SAFEGUARDS IN PLACE AT OUR OFFICE INCLUDE:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

TYPES OF INFORMATION THAT WE GATHER AND USE:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us.
- From your medical history, treatment notes, all test results, and any letters, faxes, emails, or telephone conversations to or from your other health care providers.
- From health care providers, insurance companies, Worker's Compensation insurance providers and your employer, and other third party administrators (e.g. requests for medical records, claim payment information).

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. You may revoke your consent to us at any time: however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. This will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

I have received a copy of the Notice of Privacy Practices. I understand this notice defines my rights under the federal regulations, and is intended to comply with federal patient privacy rights.

I have read the above policies and agree to their terms. I authorize you to use or disclose my health information in the manner described above.

PATIENT NAME (PRINTED)

PATIENT SIGNATURE

DATE