

MVA PATIENT INFORMATION

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PATIENT INFORMATION

Name _____ Date of Birth _____

Address _____

Cell Phone _____ Work or Home Phone _____

Email Address _____

Date of Accident _____ Were You Taken to the Hospital? ___Yes ___No

Was Any Imaging Performed? ___Yes ___No If Yes What Were the Findings? _____

Were Any Pain Medications Dispensed? ___Yes ___No If Yes, What? _____

Are You Still Taking Pain Medication? ___Yes ___No

Were You Knocked Unconscious as a Result of the Accident? ___Yes ___No

AUTO INSURANCE INFORMATION

Name of Insurance Company _____

Insurance Policy Number _____

Claim Number of Accident _____

Name of the Medical Adjuster _____

Phone Number for Medical Adjuster _____

FAX Number for Medical Adjuster _____

Mailing Address for Medical Adjuster _____

ATTORNEY

Attorney Retained ___Yes ___No If Yes, Name of Attorney _____

Phone Number of Attorney _____

Address of Attorney _____

INFORMATION REGARDING YOUR INJURIES

What Were the Extent of Your Injuries?

What Are Your Current Symptoms?

What Is Your Overall Pain Level on a Scale of 1-10 (10 is worst possible pain)

What Medical Attention or Other Modalities of Therapeutics Have You Received?

With What Results?

SUSAN BUHLER, MSOM, LAc

PH: 971.216.9913

4160 SE International Way, Suite D-205

Milwaukie, OR 97222

PATIENT HEALTH HISTORY

Personal Information

Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Numbers: Home: _____ Cell: _____

At what number may I leave a message? _____

Email Address: _____

☐ I would like to receive occasional email updates with health tips and other updates relating to An Sheng Acupuncture & Healing Arts.

Driver's License #: _____ Gender (circle one): M F Non-Binary Other: _____

Number of children you have: _____ Ages: _____

Marital status (circle one): Single Married Partnership Separated Divorced

Emergency Contact Name: _____

Relationship: _____ Telephone number: _____

Your Occupation: _____ Hours per week: _____

Business Address: _____

Business Phone: _____

Do you enjoy your job? _____

How did you hear about my clinic? (check one)

Referral ☐ Google ad ☐ Google search ☐ Google maps ☐ Facebook ☐ LinkedIn ☐ Yelp ☐

Insurance directory ☐ Health-profs.com ☐ Print ad ☐ Print directory ☐ Other: _____

Chief Health Concerns

What are your most important health concerns and what treatments have you used in the past?

1. Health concern: _____ past treatment: _____

2. Health concern: _____ past treatment: _____

3. Health concern: _____ past treatment: _____

With what results? _____

Any other concerns: _____

Please list any physicians, therapists, or other practitioners you are seeing. May we contact them? Y / N

Are you aware of any allergies to food, drugs, or environmental allergens (cats, mold, dust)? If yes, please explain: _____

SELF AND FAMILY HISTORY

Hospitalizations, Surgeries and Procedures

What hospitalizations and/or surgeries have you had, and dates? Please include any childhood hospitalizations or surgeries: _____

Serious Illnesses, Accidents and Injuries

Please list any serious illnesses, accidents or injuries you have had with dates, including childhood illnesses, accidents and injuries: _____

Do You Suffer From Any Medically Diagnosed Auto-Immune Disorders?

What diagnostic imaging studies or other testing have you had and dates?

__ Bone density scan __ Mammogram __ Electrocardiogram __ Electroencephalogram __ X-rays
__ CT scan __ MRI __ Colonoscopy __ Endoscopy __ CBC __ Stool test __ Urine test
__ Allergy test Other: _____

Medications and/or Supplements

Do you take or use any of the following?

☐ Pain relievers (aspirin, ibuprofen)	☐ Antacids	☐ Laxatives
☐ Diet pills, appetite suppressants	☐ Birth control	☐ Antibiotics
☐ Cortisone (cream or pills)	☐ Sleeping pills	☐ Medical Marijuana

Please list any prescription medications, over-the-counter medications, vitamins, or other supplements you are taking: _____

General

Height: _____ Weight: _____ lbs. Weight one year ago: _____ lbs.

Maximum weight: _____ lbs. When? _____

Overall rate your energy level on a scale of 1-10? _____

Blood Pressure and Date Last Checked: _____

Family History

Is your father still living? Yes; his age _____ No; age at time of death _____

Cause of death: _____

Is your mother still living? Yes; her age _____ No; age at time of death _____

Cause of death: _____

Do you have a family history of any of the following (please circle):

Anemia	Diabetes	Hay fever/hives	Liver disease
Arthritis	Epilepsy	Heart disease	Mental illness
Asthma	Gall bladder disease	Heart murmur	Stroke
Cancer	Glaucoma	High blood pressure	Tuberculosis
Cataracts	Menstrual problems	Kidney disease	Goiter

Others, Please list: _____

Health Habits and Life-Style

Please describe your exercise routine: _____

How many 8oz servings of nonalcoholic beverages do you drink each day? ____ What are they? _____
Servings of caffeinated beverages each day? ____ Alcoholic beverages each day? ____ week? _____
Do you smoke or chew? ____ If yes, how much per day? ____ Have you ever tried quitting? ____
Would you like to quit? _____

Please describe your typical diet and how many meals you eat each day: _____

What did you eat yesterday?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Are there any foods you crave? ____ If yes, what are they? _____

Do you use any recreational drugs? If yes, which ones and how often? _____

Rate your stress level on a scale of 1-10: ____ What are your sources of stress? _____

When under stress, do you tend towards any emotional state such as worry, depression, fear, frustration, or anger? _____

What practices do you have for stress management (for example exercise, meditation, yoga, qi gong, etc.): _____

How many hours of sleep do you get on average in a night? _____

What time do you usually go to bed? _____

Please list your interests and hobbies:

REVIEW OF SYSTEMS

Please mark a “x” next to any conditions you currently have, a ‘check’ next to any conditions you’ve had in the past, and if you’re unsure about a condition use a “?”:

Head

- ☐ Headaches
- ☐ Head injury
- ☐ Migraines
- ☐ Jaw/TMJ problems

- ☐ Sinus problems
- ☐ Frequent colds

Ears

- ☐ Ringing
- ☐ Earaches
- ☐ Dizziness
- ☐ Impaired hearing
- ☐ Itching

Mouth/Neck/Throat

- ☐ Lumps
- ☐ Goiter
- ☐ Frequent sore/dry throat
- ☐ Painful or stiff neck
- ☐ Gum problems ☐ Dental cavities
- Do you still have your tonsils? Y / N
- Did you have your adenoids removed as a child? Y / N

Nose/Sinuses

- ☐ Stuffiness
- ☐ Hay fever
- ☐ Loss of smell
- ☐ Nose bleeds

Eyes

- ☐ Blurred vision
- ☐ Glasses/contacts
- ☐ Spots in eyes
- ☐ Cataracts ☐ Glaucoma
- ☐ Tearing/dryness

Musculoskeletal

- ☐ Joint pain; where _____
- ☐ Arthritis
- ☐ Muscle spasms/pain _____
- ☐ Sciatica

Skin

- ☐ Rashes
- ☐ Lumps
- ☐ Color changes

- ☐ Psoriasis
- ☐ Acne/pimples
- ☐ Itching

- ☐ Eczema/hives
- ☐ Boils
- ☐ Loss of hair

Urinary

- ☐ Incontinence
- ☐ Kidney stones
- ☐ Frequent UTIs
- ☐ Frequent urination in day
- ☐ Frequent urination at night
- ☐ Painful urination

Neurological

- ☐ Seizures
- ☐ Paralysis
- ☐ Loss of memory
- ☐ Numbness/tingling
- ☐ Muscle weakness
- ☐ Shooting pains

Blood/Peripheral Vascular

- ☐ Anemia
- ☐ Leg pain
- ☐ Cold hands/feet
- ☐ Easy bruising
- ☐ Thrombophlebitis
- ☐ Varicose veins

Respiratory

- ☐ Asthma
- ☐ Cough
- ☐ Wheezing
- ☐ Pleurisy
- ☐ Bronchitis
- ☐ Pneumonia

- ☐ Emphysema
- ☐ Spitting up blood
- ☐ Tuberculosis
- ☐ Sleep apnea

Cardiovascular

- ☐ Chest pain /tightness
- ☐ Murmur
- ☐ Fainting
- ☐ Pressure in the chest
- ☐ Heart disease
- ☐ Ankle swelling

- ☐ Myocarditis
- ☐ Low blood pressure
- ☐ High blood pressure

- ☐ Pace maker
- ☐ Palpitations

Gastrointestinal

- ☐ Diarrhea or loose stools
- ☐ Constipation
- ☐ Ulcers
- ☐ Black stools
- ☐ Hemorrhoids
- ☐ Gall bladder removed
- ☐ Appendix removed
- ☐ Heartburn/Reflux/GERD
- ☐ Abdominal pain
- ☐ Liver disease
- ☐ Excessive gas
- ☐ Abdominal bloating
- ☐ Nausea/vomiting

Mental/Emotional

- ☐ Mood swings
☐ Nervousness
☐ Anxiety
☐ Depression
☐ Excessive anger
☐ Frequent crying
☐ Excessive worry
☐ Eating disorders
☐ Panic attacks
☐ Diagnosis of Bipolar Disorder
☐ Insomnia, hard time falling asleep or staying asleep

Endocrine

- ☐ Hypothyroid
☐ Hyperthyroid
☐ Excessive thirst
☐ Excessive hunger
☐ Cold intolerance
☐ Heat intolerance
☐ Diabetes
☐ Night sweats

Men's Health

- ☐ Hernias
☐ Prostate problems
☐ Venereal disease;
 If yes, which _____
☐ Impotence
☐ Discharge or sores
☐ Testicular masses/pain
☐ Painful urination
☐ Dribbling urination

Women's Health

Menstrual Cycle Regular? Y/N If no, please elaborate _____

- | | |
|---|--|
| ☐ Age of first menses | ☐ Age of last menses (if menopausal) |
| ☐ Length of cycle | ☐ Date of last annual exam/PAP |
| ☐ Duration of menses | ☐ Pregnant? If yes, which trimester are you in? |
| ☐ History of Miscarriages? | If yes how many? _____ |
| ☐ History of Abortions? | If yes, how many? _____ |

Do you use any form of birth control? If yes, what kind of birth control and for how long?

Have you ever been prescribed birth control pills or other hormonal therapy for managing problematic menstrual symptoms? Y / N

- | | | |
|---|--|--|
| ☐ Painful menses | ☐ Endometriosis | ☐ Ovarian cysts |
| ☐ Heavy flow | ☐ Fertility problems | ☐ Cervical dysplasia |
| ☐ Breast tenderness | ☐ Venereal disease; | ☐ Bleeding or spotting between cycles |
| ☐ Cycles irregular | If yes, which _____ | ☐ Sexual difficulty |
| ☐ Abnormal PAP | ☐ PMS | ☐ Cramps |
| ☐ Breast lumps | ☐ Blood clots during menses | ☐ Nipple discharge |
| ☐ Do self breast exams | ☐ Low back pain during menses | ☐ Vaginal discharge |
- Y/N
- ☐ Changes in bowel movements just before or during menses

Is There Anything Else You Would Like Me To Know To Better Serve You?

PATIENT (OR GUARDIAN) SIGNATURE AND DATE:

Signature

Date

CONSENT TO TREAT

Susan Buhler, MSOM, LAc
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Phone: 971.216.9913

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances by the above-named licensed acupuncturist. I understand that acupuncturists practicing in the state of Oregon 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 practitioners.

Acupuncture/Moxibustion: I understand that my acupuncture treatment could include the insertion of needles through the skin, the application of heat to the skin, or both, 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 could result, including but not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning the use of acupuncture and Chinese herbs and their effects have been given to me, and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances 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. *Should I experience any problems that I associate with these substances, I should suspend taking them and call the above provider as soon as possible.*

Acupressure/Cupping: I understand that I may also be given acupressure/cupping 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: bruising, 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.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ **Date:** _____

Printed Name: _____ **DOB:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____

NOTICE OF PRIVACY PRACTICES & CANCELLATION POLICY

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Each time you receive an acupuncture treatment program, a record is made. Typically, this record contains your symptoms, examination observations, test results, notes, treatments given and plans for future treatment/goals. Understanding your health information and how it is used helps to ensure that it is accurately used and disclosed appropriately and that you make informed decisions when authorizing disclosure to others (whether to your primary care physician [PCP] or other healthcare providers/parties sharing in your treatment).

Per HIPAA (Health Insurance Portability & Accountability Act) guidelines, all clinics are required to provide their clients with a copy of their privacy practices. This describes how medical information about you may be used and disclosed and how you can get access to this information.

NO information about your condition will be given to your employers, friends or relatives without your permission (except if required by court of law). We want you to fully understand your condition and your treatment. If you do not understand something, please feel free to ask questions. Also, your suggestions or complaints are important to us because we are interested in ways that might improve our services.

By my signature below, I acknowledge (please check only one):

- ☐ I have been notified of the availability of the Privacy Practices, but decline a copy at this time, knowing it will be provided to me if requested.
- ☐ I would like to receive a full copy of the Privacy Practices.

OPTIONAL: Furthermore, I authorize my practitioner to discuss my health condition with the designated individual(s) below (i.e. guardian, spouse, or PCP):

Name/ relationship of allowed Individual(s):

Name

Relationship

Print Name

Signature

Date

48-Hour Cancellation Policy

I require a minimum of 48-hour notification of cancellation prior to the scheduled appointment time. Patients who cancel with less than 48 hours notice, or do not show up for their scheduled appointment will be charged a fee. **This fee is \$105 for a missed appointment.**

I realize that emergencies do come up from time to time, so in the event of an illness, family emergency or other events out of your control, the cancellation fee will be waived. Forgetting appointments, changing your mind, etc., you will be charged. If there are any problems with this policy, then please discuss them directly with me. If you are ill, please call ahead of time to see if acupuncture is the best option for you. Thank you for your understanding.

By my signature below, I acknowledge this cancellation policy and the associated fees.

Signature

Date