

# WELCOME TO OUR CLINIC

Please take a few minutes to answer the following questions so that we may better assist you with your health care needs. All of your answers will be held strictly confidential. If you have any questions, please do not hesitate to ask. Thank you.

## PATIENT REGISTRATION INFORMATION

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
LAST Name FIRST Name Middle Initial

Address \_\_\_\_\_  
No., Street City State Zip

Phone: (home) \_\_\_\_\_ (mobile/work) \_\_\_\_\_ E-Mail \_\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female Status:  Single  Married  Other  Employed  FT student  PT student

Employer or School Name \_\_\_\_\_ Occupation \_\_\_\_\_

How did you learn about our clinic?  Family/friend: \_\_\_\_\_  Health professional: \_\_\_\_\_  
 Insurance directory  Phone book  Walk-in  Website  Other \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## FINANCIAL & INSURANCE INFORMATION

**Please choose one:**  SELF PAY: I will pay my balance in full at time of service (cash, check, MC, VISA accepted).  
 INSURANCE: I have medical insurance that covers acupuncture services.  
\*\*Please note, we cannot bill insurance carriers for medical conditions that are not covered by your specific plan.

PRIMARY Insurance Carrier \_\_\_\_\_ Type:  Health insurance  PIP (auto)  Workers Comp  
Insurance ID# \_\_\_\_\_ Group/Acct# \_\_\_\_\_ Plan/Program Name \_\_\_\_\_

Patient's Relationship to subscriber:  self  spouse  child  other \_\_\_\_\_ Subscriber:  Male  Female

Subscriber's Name \_\_\_\_\_ Subscriber's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
LAST Name FIRST Name Middle Initial

Subscriber's Address \_\_\_\_\_ Subscriber's Phone \_\_\_\_\_  
No., Street City State Zip

**Are you covered by another health benefit plan?**  No  Yes (If yes, please complete section below)

SECONDARY Insurance \_\_\_\_\_ Type:  Health insurance  PIP (auto)  Workers Comp  
Insurance ID# \_\_\_\_\_ Group/Acct# \_\_\_\_\_ Plan/Program Name \_\_\_\_\_

Patient's Relationship to subscriber:  self  spouse  child  other \_\_\_\_\_ Subscriber:  Male  Female

Subscriber's Name \_\_\_\_\_ Subscriber's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
LAST Name FIRST Name Middle Initial

Subscriber's Address \_\_\_\_\_ Subscriber's Phone \_\_\_\_\_  
No., Street City State Zip

## ASSIGNMENT OF BENEFITS & RECORDS RELEASE

I certify that the above information is complete and accurate to the best of my knowledge and belief. I agree to notify this provider immediately whenever I have changes in my health condition or health insurance coverage.

I hereby authorize the **release of any medical information** required to secure the payment of benefits. I further agree and authorize the above practitioner and/or any provider or supplier of services in this office to submit claims for benefits, for services rendered, without obtaining my signature on each insurance claim.

I hereby authorize and **assign directly** to Joon Hee Lee, L.Ac. **payment of all owed benefits** otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf for my dependents. In the event that this account is turned over to an attorney for collection, I understand that I will be responsible for any court costs and/or filing fees. This authorization shall remain valid until written notice is given by me revoking said authorization.

Signature of Patient (or Authorized Representative) \_\_\_\_\_

\_\_\_\_\_ Date

Please PRINT name of Patient (or Authorized Representative) \_\_\_\_\_

\_\_\_\_\_ Relationship to Patient

*Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.*

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Gender:  M  F Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Type: A B O AB

**CASE HISTORY**

What is the main problem you would like us to help you with? \_\_\_\_\_

Is this problem the result of:  Auto Accident (State: \_\_\_ )  Employment  Injury  Other: \_\_\_\_\_

How and when did this problem begin (be specific)? \_\_\_\_\_

To what extent does the problem interfere with your daily activity (work, exercise, sleep, sex, etc.)? \_\_\_\_\_

Have you seen any other physician about this condition?  Yes  No If yes, when? \_\_\_\_\_

Physician's Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Have you been given a diagnosis for the problem? If so, what? \_\_\_\_\_

Have you had any tests taken for this problem (X-rays/CAT Scans/MRI)?  Yes  No If yes, when? \_\_\_\_\_

Test(s) results: \_\_\_\_\_

What kind of treatments have you tried? \_\_\_\_\_

Other concurrent therapies: \_\_\_\_\_

**PAST MEDICAL HISTORY (please note dates):**

Cancer: \_\_\_\_\_ Hepatitis: \_\_\_\_\_ Rheumatic Fever: \_\_\_\_\_

Diabetes: \_\_\_\_\_ High Blood Pressure: \_\_\_\_\_ Thyroid Disease: \_\_\_\_\_

Heart Disease: \_\_\_\_\_ HIV/AIDS: \_\_\_\_\_ Other: \_\_\_\_\_

Surgeries & Hospitalization (types & dates): \_\_\_\_\_

Significant Traumas: \_\_\_\_\_

Significant Dental Work: \_\_\_\_\_

X-Rays/CAT Scans/MRI/Special Studies: \_\_\_\_\_

Any Scars on your body: \_\_\_\_\_

Allergies (drugs, chemicals, foods, etc.): \_\_\_\_\_

Occupational Stress (chemical, physical, psychological): \_\_\_\_\_

Your Birth History (prolonged labor, forceps, premature, etc.): \_\_\_\_\_

What was your recent blood pressure reading? \_\_\_\_\_ When was this reading taken? \_\_\_\_\_

Do you have any infectious diseases?  No  Yes If yes, please specify: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

**Family Medical History:**

- Cancer
- Heart Disease
- Asthma
- Diabetes
- Stroke
- Allergies
- High Blood Pressure
- Seizures
- Other \_\_\_\_\_

**Medications:**

What medications and/or supplements are you currently taking? \_\_\_\_\_  
\_\_\_\_\_

Have you had any courses of antibiotics recently?  Many  A few  1 or 2  None

**LIFESTYLE**

How many hours per night do you sleep? \_\_\_\_\_ Do you wake rested?  Yes  No

Exercise routine: \_\_\_\_\_

Are you or have you been on a restricted diet? What kind and why? \_\_\_\_\_  
\_\_\_\_\_

Please indicate usage per day or per week:

Cigarettes \_\_\_\_\_ per \_\_\_\_\_ Coffee \_\_\_\_\_ per \_\_\_\_\_ Tea \_\_\_\_\_ per \_\_\_\_\_

Alcohol \_\_\_\_\_ per \_\_\_\_\_ Soft Drinks \_\_\_\_\_ per \_\_\_\_\_ Other \_\_\_\_\_ per \_\_\_\_\_

Please describe your average daily diet:

Morning: \_\_\_\_\_

Afternoon: \_\_\_\_\_

Evening: \_\_\_\_\_

**Do you suffer from any of the following?** (Check all that apply, and for each note if it is current or past)

**General**

- Recurrent Infections
- Night Sweats
- Sweat easily
- Bleed or bruise easily
- Strong thirst (prefer hot or cold?)
- Thirst with no desire to drink
- Fatigue
- Sudden energy drops  
Time of day \_\_\_\_\_
- Poor Sleep
- Tremors
- Poor Balance
- Edema
- Underweight
- Overweight

- Oozing
- Pimples
- Dry skin / scalp
- Recent moles
- Changes in hair/skin
- Other \_\_\_\_\_

**Head/Eyes/Ears/Nose/Throat**

- Headaches  
Where \_\_\_\_\_  
When \_\_\_\_\_
- Migraines
- Dizziness
- Discharge from ear
- Poor hearing
- Ringing in ears
- Blurry vision
- Night blindness
- Color blindness
- Spots in front of eyes

- Eye Pain
- Excessive Tearing
- Squint
- Glasses
- Sore eyes
- Facial Pain
- Nose bleeds
- Nasal discharge
- Blocked nose
- Snoring
- Grinding teeth
- Teeth problems
- Recurrent sore throat
- Hoarseness
- Tonsillitis
- Swollen glands
- Sores on lips/mouth
- Other \_\_\_\_\_

**Skin**

- Rashes
- Itching
- Eczema

Patient's Name: \_\_\_\_\_

**Cardiovascular**

- Pacemaker
- High Blood Pressure
- Low Blood Pressure
- Chest discomfort/pain
- Heart Palpitations
- Cold hands or feet
- Swelling of hands or feet
- Blood Clots
- Spider veins
- Fainting
- Other \_\_\_\_\_

**Respiratory**

- Difficulty breathing
- Pain with breathing
- Shallow breathing
- Shortness of breath
- Production of phlegm  
Color \_\_\_\_\_
- Recurrent cough
- Bronchitis
- Pneumonia
- Asthma/Wheezing
- Status asthmaticus
- Other \_\_\_\_\_

**Digestion**

- Bad breath
- Change in appetite
- Nausea
- Vomiting
- Heartburn
- Indigestion
- Belching
- Abdominal pain or cramps
- Weight gain
- Weight loss
- Loose stools / Diarrhea
- Strong smelling stools
- Bloody stools
- Green stools
- Black stools
- Constipation  
(not daily, or difficult)
- Pain with passing stools
- Gas
- Rectal pain
- Hemorrhoids
- Anorexia nervosa
- Bulimia
- Other \_\_\_\_\_

**Genito-urinary**

- Pain on urination
- Urgency with urination
- Frequent urination
- Blood in urine
- Decrease in urinary flow
- Unable to hold urine
- Incontinence at night
- Dribbling urination
- Kidney stones
- Prostate problems
- Impotency
- Changes in sexual drive
- Rashes
- Do you wake at night to urinate?  
How many times? \_\_\_\_\_
- Other \_\_\_\_\_

**Gynecological**

- # of pregnancies \_\_\_\_\_
- # births \_\_\_\_\_
- # premature births \_\_\_\_\_
- # abortions \_\_\_\_\_
- Age of 1<sup>st</sup> menses \_\_\_\_\_
- # days between menses \_\_\_\_\_
- Duration of menses \_\_\_\_\_
- 1<sup>st</sup> day of last menses \_\_\_\_\_
- Age of menopause \_\_\_\_\_
- Date of last PAP \_\_\_\_\_

- PMS
- Irregular periods
- Painful periods
- Light periods
- Heavy periods
- Clots
- Fibroids
- Endometriosis
- Infertility
- Vaginal discharge
- Vaginal sores
- Breast lumps
- Nipple discharge
- Postcoital bleeding
- Other \_\_\_\_\_
- Do you practice birth control?  
 yes  no  
What type and for how long?  
\_\_\_\_\_
- Are you pregnant now?  
 yes  no

**Musculoskeletal**

- Neck ache/pain
- Back ache/pain
- Knee ache/pain
- Shoulder pain
- Elbow/Forearm pain
- Hand/Wrist pain
- Foot/Ankle pain
- Joint/Bone problems
- Torn tissues
- Prostheses
- Muscle pain/weakness
- Hernia
- Other \_\_\_\_\_

**Neurological**

- Seizures
- Nerve damage
- Paralysis
- Stroke
- Sleep disorder
- Concussion
- Vertigo
- Lack of coordination
- Loss of balance
- Poor memory
- Difficulty in concentrating
- Other \_\_\_\_\_

**Behavioral**

- Vacant
- Moody
- Easily susceptible to stress
- Aggressive/Bad temper
- Lose control of emotions
- Anxiety
- Panic Attacks
- Depression
- Fear
- Substance abuse
- Other \_\_\_\_\_

Have you ever been treated for emotional problems?  
 yes  no

Have you ever considered or attempted suicide?  
 yes  no

**INFORMED CONSENT FOR ACUPUNCTURE AND ORIENTAL MEDICINE**

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the *Oriental Materia Medica* by Joon Hee Lee, Licensed Acupuncturist (L.Ac.). On occasion, if Joon Hee Lee, L.Ac. is not available, I consent to treatment by a substitute L.Ac. as designated by Joon Hee Lee, L.Ac. and approved by myself. The treatments that will possibly be administered are described below.

- **Acupuncture/Moxibustion:** I understand that acupuncture is performed by the insertion of needles through the skin or by 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 may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, temporary 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.
- **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 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 effect 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 to which I associate with these substances, I understand that I should suspend taking them and call my practitioner. Some herbs may be inappropriate during pregnancy and breastfeeding. I accept full responsibility to inform my practitioner of a suspected or confirmed pregnancy, or if I am a nursing mother.
- **Cupping:** I understand that cupping, which is performed by placing specially designed cups on the surface of the body, may be given 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.
- **Heat Treatment with a TDP Lamp:** This is used to warm an area of the body. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns exists.

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

I have carefully read, or have had read to me, 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 further understand that I may request another person of my choice be present in the treatment room during treatment. I have the right to refuse or discontinue any treatment at any time and understand that this refusal may affect the expected results. I understand the possible risks and complications involved and I give my permission and consent to the treatment that involves the above procedures for my present and future health condition(s).

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I understand that my practitioner may need to contact my primary care practitioner if my condition needs to be co-managed with my medical doctors. This coordination of care intends to manage my health condition in my best interest and assure the optimal outcome of my acupuncture treatments. Therefore, I give my authorization to my practitioner to contact my medical doctor if/when necessary.

**Treatment of Pediatric Patients:** I understand that treatment of young children has some risk and should be coordinated with the child’s physician. If I am signing for my child under the age of eighteen (18), I give my authorization to my practitioner to contact my child’s medical doctor if/when necessary.

\_\_\_\_\_  
Signature of Patient (or Authorized Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please PRINT name of Patient

If an Authorized Representative has signed, please print your name: \_\_\_\_\_