Acupuncture Treatment Center

1700 Wells Road, #28. Orange Park, FL 32073 904-269-4070

Patient Medical History

Today' date _____

Last name _____ First name _____ Middle initial ____ Sex_____ Age _____

Birth date _____Marital status _____ Occupation _____ Number of years _____

Home address _____ City _____ State ____ Zip _____

Telephone, day _____ evening _____ Mobile _____ Social Security Number _____/_____/_____

Self-Pay _____ Car accident _____ Workmen' Comp _____ Other Health Program _____

Your insurance company _____ Phone No. _____I.D. No. _____

Co-pay amount _____ Have you been treated by acupuncture before _____ Place _____

Are you taking any other therapies at the same time, if yes please list _____

Are you taking any medications, please list _____

_____

Are you hungry ___ Exhausted ___ Nervous ___ at the present time. (Women) **Are you pregnant at the present time** ____?

Please answer the following questions 請逐項填寫 **What medical condition do you request to treat**？就診原因

1. _____

2. _____

1. Have you ever had the following? (check each box) 是否曾有以下情形

	Yes	No		Yes	No
1. Frequent colds 經常傷風感冒			12. Stomach or intestinal disease 胃腸病		
2. Sinusitis 鼻竇炎			13. Diabetes or sugar in urine 糖尿病		
3. Tuberculosis 肺結核			14. Thyroid trouble 甲狀腺 Hyper 亢	Hypo 低	
4. Heart attack 心臟病發作			15. Cancer or tumor: 癌或腫瘤:		
5. Heart murmur 心臟雜音			16. Stroke: 中風:		
6. High cholesterol 高脂血症			17. Blood disease: 血液疾病:		
7. Kidney disease 腎病			18. Sexual transmittal disease 性病		
8. Kidney stones 腎結石			19. HIV positive 艾滋病後天免疫不全症		
9. Hepatitis 肝炎 A B C			20. Loss of balance / seizures 失平衡/顛癇		
10. Gall bladder stone/disease 膽病結石			21. Alcoholics and drug addiction 酗酒及藥癮		
11. Jaundice 黃膽			22. Allergy to drugs: 藥物過敏:		

2. Have you recently been bothered with the following 近來是否有以下情形

1. Easy fatigability 易倦			4. Memory defect 記憶力減退		
2. Sleepy all the time 嗜睡			5. Hearing loss 聽覺減退		
3. Aversion to cold 畏寒			6. Easy catch cold or flu 抵抗力低易生病		

3. Energy Level 體力和精神情況

4. Current Status 目前有無以下情形

Sel. = Seldom 偶爾 Freq. = Frequent = 經常 No = None = 不曾有

	Sel.	Freq.	no
Skin 皮膚			
1. Easy bleeding 易出血			
2. Skin rash, sores 皮膚斑疹或疼痛			
3. Itching 皮膚癢癬			
4. Ulcerations 皮膚潰瘍			
Head 頭部			
5. Severe or freq. headache 經常頭痛			
6. Migraine 偏頭痛			
7. Hair loss 掉頭髮			
Eyes 眼			
8. Change in vision 視力改變			
9. Double vision 複視			
Ears 耳			
10. Dizziness/fainting 頭昏或暈倒			
11. Ringing in ears 耳鳴			
12. Vertigo 眩暈			
Nose 鼻			
13. Sneezing 流鼻水			
14. Hay fever 花粉敏感症			
Throat, Mouth 喉， 口			
15. Cough 咳嗽			
16. Coughing up blood 咳嗽帶血			
17. Sore throats 喉嚨痛			
18. Hoarseness 喉嚨沙啞			
Lungs, Chest, Breast 肺， 胸， 乳			
19. Wheezing 哮喘			
20. Pneumonia 肺炎			
21. Dyspnea 呼吸困難			
Cardiovascular 心血管			
22. Rapid heart beat 心跳過速			
23. Irregular heart beat 心跳不規則			
24. Shortness of breath 氣短或氣促			
25. Chest pain or pressure 胸悶或胸痛			
26. Ankle swelling 腳踝腫			
27. Extremely exhaust 極度疲勞			
28. Hypertension 高血壓	Systolic	Diastolic	
Gastrointestinal & Abdomen 消化道			
29. Indigestion 消化不良			
30. Diarrhea 腹瀉			
31. Abdominal cramps 腹痛			
32. Constipation 便秘			
33. Blood in the stool 大便有血			
34. Irritable bowel syndrome 腸易激綜合徵			
35. Difficulty swallowing 吞咽困難			
36. Nausea or vomiting 惡心或嘔吐			
37. Heartburn 胃或食道燒灼			
38. Anorexia 厭食			
Genitourinary 泌尿系統			
39. Frequent urination 多尿			
40. Painful urination 小便刺痛			
41. Blood in the urine 尿中帶血			

	Sel.	Freq.	no
42. Decreased strength of urine 小便無力			
43. Frequent urination in evening 夜尿多	Times 次數		
44. Dribbling 尿淋漓不斷			
45. Retention 尿滯留			
46. Incontinence 尿失禁			
47. Enuresis 遺尿			
Metabolism 新陳代謝			
48. Night sweats 夜汗或大汗			
49. Fever or chills 冷熱交替			
50. Decrease appetite 食慾減退			
51. Loss more than 10 Pounds 減輕十磅			
52. Gain more than 10 Pounds 增加十磅			
53. Increased appetite 食慾增加			
54. Extreme thirst 極度口渴			
Neuromuscular 肌肉和神經			
55. Neck / shoulder pain 頸/肩痛			
56. Backache / lower back pain 背痛			
57. Hip / knee pain 臀/膝痛			
58. Arthritis pain 關節炎疼痛			
59. Osteoarthritis pain 骨關節炎痛			
60. Pain or cramps in muscles 肌肉痛			
61. Numbness/ Tinging 肢體麻刺感			
62. Abnormal sensation on limbs 四肢異常			
63. Weakness 虛弱			
64. Convulsions 抽筋			
65. Tremor 抽搐			
66. Atrophy 肌萎縮			
67. Paralysis 癱瘓			
68. Trigeminal neuralgia 三叉神經痛			
Mental state 精神狀態			
69. Insomnia 失眠			
70. Nervousness 神經質			
71. Irritability 焦躁過敏			
72. Anxiety 焦慮			
73. Depressed 沮喪			
Male 男性			
74. Colliculitis 精阜炎			
75. Prostatic disorder 前列腺疾病			
76. Sexual disorder 性功能障礙			
77. Impotence 陽萎			
OB GYN 女性			
78. 1st day of last menses 上次月經第一日			
79. Birth control method 避孕方式			
80. Miscarriage 流產	Times 次		
81. Painful menstruation 痛經			
82. Abnormal periods 月經不規則			
83. Cycle early or delay 月經提前或延緩			
84. Length of cycle 月經週期是幾日			
85. Perimenopause Symptoms 停經綜合症	Yes	No	
86. Menopause 已絕經			
87. Hormone replacement therapy. 激素治療中			

5. CONSENT FOR TREATMENT 同 意 治 療

I, the undersigned, give consent for treatment to include any of all of procedures listed below:

Office Visit	Acupuncture
Acupressure	Electric Acupuncture (with Electric Stimulation Machine)
Infrared Heat Lamp Therapy	Cupping
Therapeutic Exercises	Tui-Na (Chinese Therapeutic Massage)
Herbal Therapies	

I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatment. Every attempt will be made to protect me from harm, but there may be unfavorable skin reaction, unforeseen nerve damage, possible infection, unexpected very minor bleeding and/or other complications not anticipated. I realize that I may withdraw from the program at any time. I also understand that **under no circumstances that my personal information will be share or passed to any third party**.

FEES, INSURANCE, AND PAYMENT AGREEMENT 保 險 付 款 或 自 付 治 療 費 用 等

The fees charged in this office are comparable to those charged by other specialists with similar qualifications in this geographic area.

The fees for office services are payable at the time of the visit, except in cases enumerated below. For your convenience, we accept cash, personal checks, Master charge, and Visa.

If you carry health insurance covering any service that we offer, it is your responsibility to provide us with the proper insurance claim forms and a proper identification card showing proof of coverage on your first visit. Remember, the fee for treatment is an obligation that your have with us.

If you are a patient of an industrial accident, you must provide us with an authorization signed by your employer or supervisor authorizing the clinic to provide medical services to your on your first visit. It is also your responsibility to provide us with the name and address of the workers' compensation carrier.

For those who have private health insurance coverage, please be sure that your portion of the insurance form is carefully completed and signed before bringing it to us on your first visit. You will be expected to assign the payment to the clinic. We urge you to carefully review your insurance coverage prior to your office visit. Policies are often confusing, misleading, and rarely pay everything. Please understand that we have no payment agreements with the insurance companies. Insurance benefits are a matter between the patients, i.e. the insured, and his or her insurance companies. We must emphasize that should there be dispute between you and your insurance company, and your insurance company refuses to make payments to us, you will become directly liable for payment of the medical bill.

In those cases, we reserve the right to make the financial charge at an interest rate of 1.5% per month for every month that the account remains overdue, after 30 days. Charge of return check is forty dollars per check issued. If for some reason, I do not pay my portion of what is owed, and Acupuncture Treatment Center has to take legal action to collect monies owed to them, I agree to pay all attorney, and legal fees incurred by Acupuncture Treatment Center.

If you agree to the above terms, please sign at the space provided below.

Patient's signature & name in print 簽 名 Date 日 期

6. How did you hear about us 您 是 如 何 知 道 這 兒

1. Family members / Friends 家人朋友介紹 Name: Phone:		2. Doctor referral. Please include Doctor and Clinic name, phone number 西醫轉診：醫師及電話	
3. Web site 網頁訊息		4. Your E-mail Address 您的電子郵箱地址	
5. Do you wish to be on our event mailing list, both by mail or E-mail? 您同意我們郵寄或用電子郵箱發送醫療資料或活動資訊給您嗎		Yes	No

Date 日期	Patient name 姓名	No. of visit	Remarks 備註

Chief Complaint 主要症狀:

When did the symptoms first started 已經有多久 _____

Patient Progress:

Improving Not improving Worse

Comments:

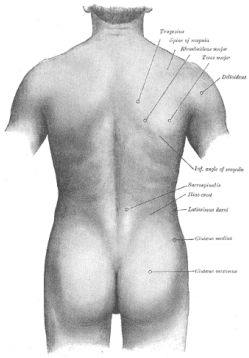
Pain/numbness/weakness level before treatment on a scale 1-10 疼痛指數

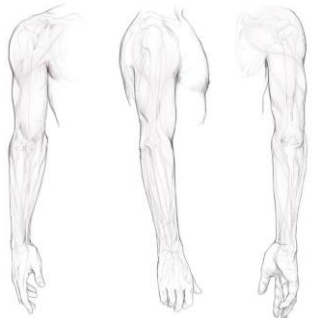
1 2 3 4 5 6 7 8 9 10

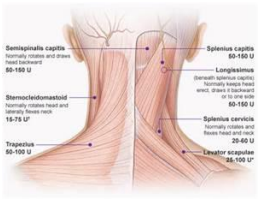
Pain/numbness/weakness level since last treatment

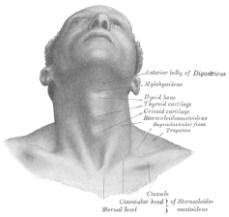
1 2 3 4 5 6 7 8 9 10

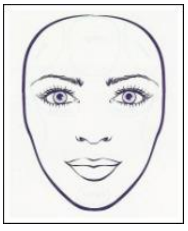
Please Circle the pain area of the body 請圈出疼痛區域

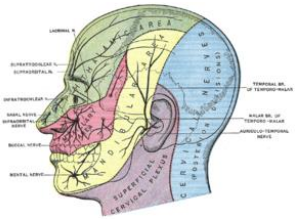


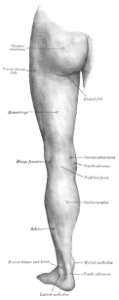


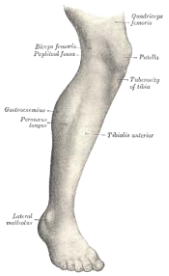


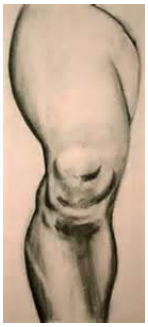


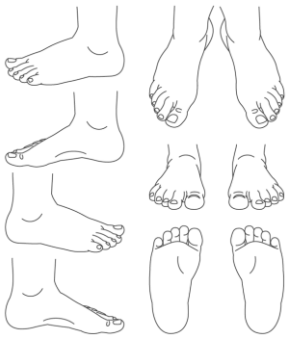












S.O.A.P. (problem, context, modifying factors, how was patient injured)

S:

O:

A:

P:

Recommendations:

Physician signature: