

**1stWellness Acupuncture & Chinese Medicine Clinic**

3503 188<sup>th</sup> ST SW, Lynnwood, WA 98037

(425) 367-9001

**(Please Print)**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Personal Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Street: \_\_\_\_\_ Apt: \_\_\_\_\_ or P.O. BOX: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: M / F Marital Status: S M W D Sep

Number of Children: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Primary Physician: Dr. \_\_\_\_\_

**Working and Insurance Information**

Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Plan/Group: \_\_\_\_\_

Policy ID#: \_\_\_\_\_ Co-pay\$: \_\_\_\_\_ Deductible\$: \_\_\_\_\_

Relationship to insured: Self Spouse Child Other

Information on insured (If other than yourself)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Employer: \_\_\_\_\_

Secondary Insurance: (if covered by more than one) \_\_\_\_\_

Policy ID#: \_\_\_\_\_

**Whom may we thank for referring**

Referred by: \_\_\_\_\_

Advertisement in: \_\_\_\_\_

Other: \_\_\_\_\_

Acupuncture and Chinese Medicine

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

Date: \_\_\_/\_\_\_/\_\_\_

**Health Related Information**

Please list the main problems that you are having, or reasons for this appointment:

---

---

---

Have you seen other health care providers for this? (If yes, please list the diagnosis and treatments)

---

---

---

**Medical History**

Serious Illnesses: \_\_\_\_\_

Surgery: \_\_\_\_\_

Major accidents: \_\_\_\_\_

Current medications: \_\_\_\_\_

Current supplements/Herbs: \_\_\_\_\_

Others: \_\_\_\_\_

Allergies (Medications, Food and Environment etc):

---

---

Habits (Coffee, Tobacco, Alcohol and Drugs etc) or Special diet and exercises:

---

---

HIV positive: (yes) \_\_\_ (no) \_\_\_

Any other problems would you like to discuss:

---

---

Acupuncture and Chinese Medicine

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

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Informed Consent to Acupuncture & Chinese Medicine Treatment**

Washington law requires that each patient be informed regarding the scope of practice in which a licensed acupuncturist is allowed to engage. Acupuncture and Chinese Medicine Clinic practice includes: use of disposable acupuncture needles and electric stimulus to stimulate acupuncture points and meridians; acupressure; dermal friction technique; infra-red heat treatment; cupping, Chinese herbs and dietary advice based on Traditional Chinese Medicine.

Side effects may occur in a small percentage of patients and may include the following: some pain following treatment in the treated area, minor bruising or bleeding, infection, burn from heat lamp, needle sickness (fainting),miscarriage, pneumothorax, and broken needle. **If you have a severe bleeding disorder, have a pacemaker, or you are pregnant, please let your provider know prior to treatment.**

**Financial Policy**

Health and accident insurance policies are arrangements between an insurance carrier and yourself. Your provider will prepare necessary reports and forms to assist you in receiving the coverage by your insurance company for the treatment. Any co-payment required by your insurance company or payment for non-insured patient is expected at the time of the visit.

**Confidential Policy**

Acupuncture and Chinese Medicine Clinic keeps a record of the health care services that the provider renders to you. We will not disclose your records to others unless you direct us to do so, or the law authorizes, or compels us to do so.

**Patient Consent**

I read the above information and agree that I am well informed regarding the treatments provided by my provider and had an opportunity to ask questions about them. I also understand that I am responsible to pay all services rendered to me that my insurance carrier does not cover. By signing below, I agree to receive the treatments. I understand that my consent covers the entire course of treatment for my present condition and for any future conditions for which I seek treatment from my provider.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent or guardian Signature: \_\_\_\_\_