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Website: www.wcmclinic.com

NEW PATIENT REGISTRATION FORM

Patient Information							
Name: Last		First		Middle		Sex	
Birth Date		Age		Marital Status			
Phone		Email		Zip Code			
Street Address		City		State			
Occupation		Employer					
Emergency Contact's Name		Relationship		Phone			
Insurance Company		Insurance Number					

Health Information
Chief Complaint and Duration:
History of Present Illness:
Past Medical History,Which Includes:
Medical History (List any medical problems and the year that you were diagnosed with):
Surgical (List any Surgeries Including pace-maker, replacement, plastic surgery, etc.):
Menstruation & Obstetric History(Only for Woman):

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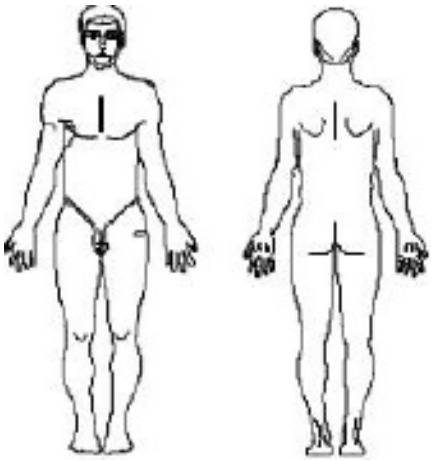
Pregnancy Yes No	Last Menstrual Period Date
Others:	
Medication (List any medications you are taking or have taken in the past 3 months):	
Allergies(If You Have, Please List Them):	
Personal/Social History (Including Exercise, Diet, Alcohol, Tobacco and Drugs):	
Family History (If Your Family Member Have Any Disease Please List Them):	



Pain Location:
Please mark the pains on the diagram

Pain Characteristic (Please tick):
SS=spasms, ST=stiffness, DP=dull pain, SP=sharp pain, SH=shooting pain, TI=tingling, NU=numbness, O=other

Pain Intensity Range (Please Rate) :
0 (no pain) - 10 (unbearable)

Factors that Aggravate or Alleviate Pain (Please Write Down):

Read and Sign

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify the providers immediately whenever I have changes in my health condition in the future.

Patient Signature: _____ Date: _____

To Be Completed by the Doctor Below

Examination:

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Auxiliary Examination:
Review of System:
Treatment Plan:
Lifestyle Modification:
Followup Plan:
Doctor Signature: _____ Date: _____

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Informed Consent Form

Acupuncture is a safe and effective method of treatment. Each patient can expect some points to be more sensitive than others, with brief pain-like sensation(s), especially where there is less flesh (near nails, fingers, etc.) It can occasionally cause slight bleeding that usually resolves with pressing dry cotton where the skin is bleeding. It is also normal for the patient to have a temporary warm, tight, sore or tingling sensation and minor bruising/lump at the acupuncture site. None of these symptoms are permanent.

Acupressure/TuiNa/Manual Therapy involves rubbing, kneading, pressing, and stroking, etc., which may result in muscle soreness at the massage site that can last several days. This technique may require disrobing. I understand all attempts will be made to assure my privacy.

Herbal Supplements are safe, effective Chinese herbs, specific to my conditions that will not affect or interact with other medications. I understand that I may request ingredients for herbs. I understand I may consult with my family doctor. I understand that if I am uncomfortable or if concerns arise, I may stop taking them at any time.

Electrical Stimulation/TENS uses micro current electricity to stimulate acupuncture points. A mild tingling sensation of electricity will be felt.

Infrared Heat involves utilizing infrared radiation. It is a safe and medically proven method of healing. If I'm pregnant or have scar tissues, diabetes or hernia, I'll inform the doctor to avoid direct infrared lighting to stomach or too closed to skin.

I have read, or have been read to me, the above consent and information, understand that Wellness Chinese Medicine & Acupuncture (WCMA) have explained all known risks and complications, and am aware of that I have the opportunity to ask questions with WCMA. I consent to treatments that involves the above procedures for my present conditions as well as future conditions. 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 that I may contact WCMA at anytime if I still have concerns or questions.

Patient Signature_____ Print Name_____ Date

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H.I.P.A.A. - Patient Authorization Form

Information to Be Used or Disclosed - The information covered by this authorization includes:

Medical Records__ Billing__ Appointments

Other:

The Information listed above will be disclosed to and/or by:

Spouse__ Children__ Parents__ Doctors

Other people or organization

Expiration Date:

This authorization is effective through *(write desired time frame)*

Unless revoked or terminated by the patient or patient's personal representative.

Patient Rights - Right to Terminate or Revoke Authorization:

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

Potential for Re-disclosure:

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

Patient Signature_____ Print Name_____ Date