SilverLake
Acupuncture & Oriental Medicine

Patient Health Information Sheet:

Name: _____ (First Middle Last)

Address: _____(Street, APT #)_____

_____(City, State, Zip)_____

Phone: _____Email: _____

Age: _____ Gender: ☐Male ☐Female

Marital status: ☐ single ☐ married ☐ divorced

DOB: __/__/_____ (mm/dd/yyyy)

Are you the primary on your insurance plan? Yes ☐ No ☐

If no. Name of Primary _____ DOB: __/__/_____ (mm/dd/yyyy)

Employer: _____Occupation: _____

Emergency Contact: _____

Relationship: _____

Phone: _____

Reason for seeking Treatment: _____

Who may we thanks for referring you? _____

Insurance Patient Only

I authorize the release of any medical or other information necessary to process insurance claim regarding my treatment received from Silverlake Clinic. I also authorize payment of medical benefits to Dr. Eun Heo / Silverlake Clinic.

Signature: _____ Date: ___ / ___/___

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Vital Sign:

B.P.: _____ HHg H.R.: _____ /Min

R.R.: _____ /Min Temperature: _____ °F

Chief Complain: Please answer all questions that apply to your condition.

List illness and/symptoms in order of importance to you/ How long you' ve had it / Intensity(0~10 : 10 is most severe)

1. _____ / _____ / _____ /10
2. _____ / _____ / _____ /10
3. _____ / _____ / _____ /10

Have you received any treatment for your condition? ☐ Yes ☐ No

If, yes, please describe: _____

_____

Are you seeking treatment for pain? ☐ Yes ☐ No

Character of pain(dull, sharp, pin and needle, achy, pulling, electric … Etc..,) _____

_____

Frequency of pain: _____

Duration of pain: _____

Trigger factor: _____

Ameliorating factor: _____

Does your pain restrict or stop your daily activities? ☐ Yes ☐ No

MEDICAL HISTORY

List any accident, surgeries, and hospitalizations, including dates:

_____

_____

_____

_____

_____

List any surgical implants: _____

List any Medications you are currently taking.

1. _____
2. _____
3. _____

List any vitamins, herbs, supplements you are currently taking reason for taking

1. _____
2. _____
3. _____

List Allergies: _____

SOCIAL HOSTORY

Do you exercise regularly? ☐ Yes ☐ No

If yes, list type and frequency: _____

Your usual diet consists of : _____

_____

FOR WOMAN ONLY

Are you pregnant? ☐ Yes ☐ No

Are you using birth control pills/shot/patch? ☐ Yes ☐ No # of Children : _____

Length of Menstrual cycle: __days Regularity: ☐ regular ☐ irregular

Period length: __ days Flow: ☐ light ☐ moderate ☐ heavy

Clots: ☐ Yes ☐ No PMS: ☐ Yes ☐ No if yes, please, describe symptoms:

_____

Informed Consent to Acupuncture and Oriental Medicine Treatment

I hereby request and consent to the performance of acupuncture treatment and other procedure within the scope of acupuncture on me (or the patient named below for whom I am legally responsible) by the licensed acupuncturist. I understand that the methods of treatment may include, but are not limited to, medicine, and nutritional counseling. I will immediately notify the licensed acupuncturist of any un-participated or unpleasant effects associated with the consumption of herbal pills or formulas.

I have been informed that acupuncture is generally safe method of treatment, but I may have some side effects, including bruising (especially on the face), numbness or tingling near the needle sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung (pneumothorax). Infection is another possible risk, although the licensed acupuncturist uses only sterile single use disposable needles. Burns and/ or scarring are a potential risk of cupping and moxibustion. I understand that while this document describes the more common risk, other side effects may occur. The herbs and nutritional supplements which are from plant, animal, and mineral sources, that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, rashes and tingling of the tongue. I will notify the licensed acupuncturist if I become or suspect I have become pregnant. I do not expect the licensed acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the licensed acupuncturist to exercise careful judgment during the course of treatment, which the licensed acupuncturist believes, based on the facts then known is in my best interest. I understand result are not guaranteed. But all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I read, or have had read to me, the above consent to treatment; have been told about the risks and benefits of acupuncture and other procedures and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

Patient Signature _____ Date _____

Or Patient representative Signature _____ Date _____

Form to be completed by Patient, notifying the Acupuncturist of Whether He/She has been evaluated by Physician, and other Information

(Pursuant to the requirement of "183.6(e)" of this title(relating to Denial of License; Discipline of Licensee) and Tex. Occ. Code Ann.,"205.351, governing the practice of acupuncture.)

I (patient's name) _____ , an notifying the acupuncturist Dr. Eun Heo of the following:

___ Yes ___ No
I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognized that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

___ Yes ___ No
I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after 120 days or 30 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I* understand that the acupuncturist is required to refer me a physician. It is my responsibility and choice whether to follow this advice.

Signature _____ Date: _____

Note:

Exemptions according to Rule 183.6 (e) Scope of Practice

3) .... An acupuncturist holding a current and valid license may without an evaluation or referral from physician, dentist or chiropractor perform acupuncture on a person for **smoking addiction, weight loss, alcoholism, chronic pain, or substance abuse.**

Notice of Privacy Policies

Our clinic is decided to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship.
This notice will remain in effect until it is replaced or amended by changes in law. We gather personal information and health information in several ways;

- Information we received from you
- Information we received from healthcare providers
- Information we received from third party payers

This information is used for treatment, payment, and healthcare operations. You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment, and healthcare operations. You may specifically authorize us to use protected health information for any purpose or to disclose your health information by submitting the authorized in writing. Such disclosure will be made to any personal representation you choose to have your protected health information.

Marketing
This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, newsletters and appointment reminders by calls, card, letters, or emails.

Disclosure
This office may use or disclose your Protected Health Information when required by law.

Patient Rights
1. Upon written request you have the right to access, review, or receive copied of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information
3. Upon written request you have the right to request that this office place additional restrictions on the disclosure of your Protected Health Information.
4. Upon written request you have the right to request that we amend your Protected Health Information.
5. You have right to receive all notices in writing.

I _____ (print) have read, reviewed, understand and agree to the statement of Privacy Policy of healthcare services in this clinic.

Patient Signature _____ Date: _____