

## Meridian Acupuncture Clinic

7357 SW Beveland St., Suite #210  
Tigard, OR 97223  
(503)692-9680  
[www.meridianacupuncture.com](http://www.meridianacupuncture.com)

### Patient Information Form

Name \_\_\_\_\_ SS# \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(last) (first) (middle) (strictly confidential)

Home Address \_\_\_\_\_  
(Street, Apt #) (city) (state) (zip)

Home Ph (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

Phone number where we can leave you a message: (\_\_\_\_\_) \_\_\_\_\_

E-mail \_\_\_\_\_ Age \_\_\_\_\_ Employer \_\_\_\_\_

Work Address \_\_\_\_\_  
(Street) (city) (state) (zip)

Weight \_\_\_\_\_ Height \_\_\_\_\_ Gender: F \_\_\_\_\_ M \_\_\_\_\_ Name you go by \_\_\_\_\_

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_ Partnership \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship to you \_\_\_\_\_ Ph (\_\_\_\_\_) \_\_\_\_\_

Who referred you to Meridian Acupuncture Clinic? \_\_\_\_\_

### Insurance Information

The insurance/billing information questions are necessary. Please provide your insurance ID card for photocopying.  
Thank you.

I understand that if I am not paying for treatment at the time of service, I need to supply Meridian Acupuncture Clinic with my Social Security Number.

Insurance Company: Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
Insured's ID or SS# \_\_\_\_\_ Group # \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

As a service to our patients, Meridian Acupuncture Clinic will submit charges for medical treatment to the patient's insurance company. However, the patient is primarily responsible for paying any and all medical expenses incurred at this office.

We may attempt to verify in advance that the patient's insurance company will pay for the specific medical procedures. Occasionally, even though coverage was verified before the medical services were provided, the insurance company denies the claim. If the insurance company denies payment or will not pay a portion of the medical bill, the patient is responsible for payment of account balance. Likewise, if the patient has not met his/her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible, in addition to whatever amounts the insurance does not pay.

*I agree to be responsible for payment of services in the event my insurance company doesn't agree to pay for these services. Not signing this document does not release you from responsibility of payment.*

\_\_\_\_\_  
Patient's or Authorized Person's Signature

\_\_\_\_\_  
Date

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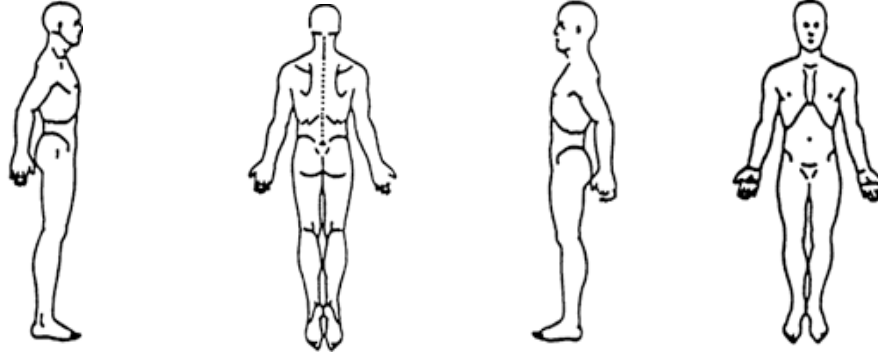
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## Body Pain

(circle the areas of pain)



## Health History

From whom are you currently receiving health care? \_\_\_\_\_

What is your chief complaint? \_\_\_\_\_

What, if any, contagious diseases do you have at this time? \_\_\_\_\_

What childhood illnesses have you had? \_\_\_\_\_

What hospitalizations have you had? \_\_\_\_\_

What allergies to drugs or foods do you have? \_\_\_\_\_

What current medications do you take? \_\_\_\_\_

## Family History

Age (if living) \_\_\_\_\_ Father \_\_\_\_\_ Mother \_\_\_\_\_ Brothers \_\_\_\_\_ Sisters \_\_\_\_\_ Spouse \_\_\_\_\_ Child(ren) \_\_\_\_\_

Health (G=Good P=Poor) \_\_\_\_\_

List any chronic conditions that run in your family \_\_\_\_\_

## Lifestyle

Do you exercise? Y \_\_\_\_\_ N \_\_\_\_\_ If yes, what kind? \_\_\_\_\_

Current Temp? (degrees) \_\_\_\_\_ In what part of your body do you hold your tension? \_\_\_\_\_

Alcohol & Tobacco Use? Y \_\_\_\_\_ N \_\_\_\_\_ If yes, please explain type and frequency \_\_\_\_\_

Blood pressure? (\_\_\_\_\_/\_\_\_\_\_) this is **with** / **without** medication (circle one)

What vitamins or other supplements do you take? \_\_\_\_\_

*If there is any additional information you would like to add, use the back of this sheet.*

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### Systems Review

For the following, please circle:

**Y**=a condition you now have

**P**=a condition you had before

**N**=a condition you never had

Depression	Y	P	N		Seizure	Y	P	N
Easily stressed	Y	P	N		Numbness or tingling	Y	P	N
Anxiety or nervousness	Y	P	N		Itching	Y	P	N
Difficulty sleeping	Y	P	N		Migraines	Y	P	N
Physically or mentally restless	Y	P	N		Headaches	Y	P	N
Acne, Boils	Y	P	N		Spots in eyes	Y	P	N
Rashes	Y	P	N		Blurring	Y	P	N
Jaw/TMJ Problems	Y	P	N		Glasses or contacts	Y	P	N
Impaired hearing	Y	P	N		Tearing or dryness	Y	P	N
Ringing in ears	Y	P	N		Glaucoma	Y	P	N
Cough	Y	P	N		Chest pain	Y	P	N
Asthma	Y	P	N		Heart Disease	Y	P	N
Sputum/Phlegm	Y	P	N		High/Low Blood Pressure (circle)	Y	P	N
Bronchitis	Y	P	N		Palpitations/Fluttering	Y	P	N
Difficulty breathing	Y	P	N		Swelling in ankles	Y	P	N
Shortness of Breath	Y	P	N		Fainting	Y	P	N
Heartburn	Y	P	N		Pain on urination	Y	P	N
Nausea/Vomiting	Y	P	N		Frequency at night	Y	P	N
Constipation	Y	P	N		Increased urinary frequency	Y	P	N
Diarrhea	Y	P	N		Inability to hold urine	Y	P	N
Blood in stool	Y	P	N		Kidney stones	Y	P	N
Gall bladder disease	Y	P	N		Joint pain or stiffness	Y	P	N
Frequent cold or infections	Y	P	N		Arthritis	Y	P	N
Easy bruising or bleeding	Y	P	N		Weakness	Y	P	N
Varicose veins	Y	P	N		Anemia	Y	P	N
Diabetes	Y	P	N		Fatigue	Y	P	N
Cancer history	Y	P	N		Hypo/Hyper Thyroid (circle)	Y	P	N
List other notable information:								

### Female Reproduction

Age of first menses					Are cycles regular	Y	P	N
Length of period _____ days					Difficulty conceiving	Y	P	N
Duration of cycle _____ days					Abnormal PAP	Y	P	N
Painful menses	Y	P	N		Clotting	Y	P	N
Heavy or excessive flow	Y	P	N		Discharge	Y	P	N
PMS	Y	P	N		Birth control	Y	P	N
Endometriosis	Y	P	N		Ovarian cysts	Y	P	N
Breast tenderness/pain	Y	P	N		Spotting	Y	P	N

### Male Reproduction

Hernias	Y	P	N		Testicular masses	Y	P	N
Testicular pain	Y	P	N		Prostate disease	Y	P	N
Impotence	Y	P	N		Discharge or sores	Y	P	N

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**Acupuncture Consent**

Acupuncture is performed by the insertion of needles through the skin, and/or by the application of heat to the skin at certain points on or near the surface of the body in an attempt to treat pain, disease, or other dysfunction.

Adverse side effects may result. These could include, but are not limited to, local bruising, minor bleeding, fainting, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to acupuncture treatment.

Acupuncturists may recommend treatment with substances from the Oriental materia medica. Adverse side effects may result from taking these substances. These include, but are not limited to, changes in bowel habits, temporary abdominal pain or discomfort, and the possible temporary aggravation of symptoms existing prior to herbal treatment. If I experience any problems to which I associate with these substances, I understand that I should stop taking them and call my practitioner.

The above treatment, alternatives, and risks have been explained to me by my practitioner. I have had an opportunity to ask questions and I hereby consent to acupuncture treatment.

\_\_\_\_\_  
Patient's or Authorized Person's Signature

\_\_\_\_\_  
Date

**Notice of Patient Privacy**  
**Health Insurance Portability and Accountability Act (HIPAA)**

Meridian Acupuncture Clinic is dedicated in preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information.

Required by law: We must have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of or disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the top right-hand side of this page indicates the date of the most current NOTICE in effect.

You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact Meridian Acupuncture Clinic (503) 692-9680. You may also Send a written complaint to the US Department of Health and Human Services.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name