

Meridian Acupuncture Clinic

7357 SW Beveland St., Suite #210
Tigard, OR 97223
(503)692-9680
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

Meridian Acupuncture Clinic

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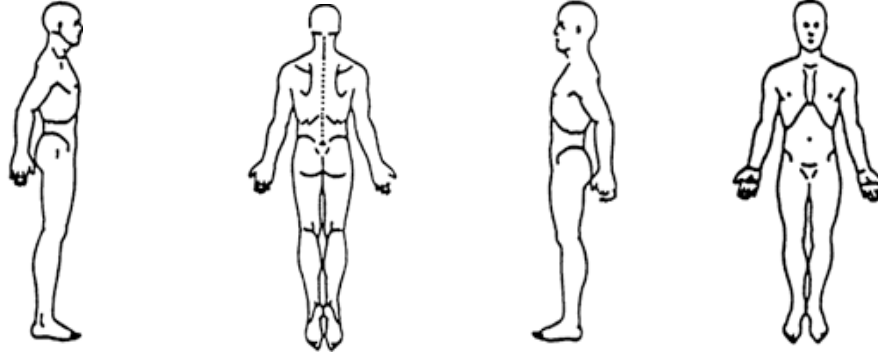
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Body Pain

(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

Symptom Survey Form
(Restricted to Professional Use)

PATIENT _____ DOCTOR _____ DATE _____

AGE _____ PHONE (_____) _____ VEGETARIAN ____Yes ____No

INSTRUCTIONS: Circle the number that applies to you. **If symptom doesn't apply, leave blank.** Use **(1)** for **MILD** symptoms (occurs once or twice a month), **(2)** for **MODERATE** symptoms (occurs several times a month), and **(3)** **SEVERE** symptoms (you are aware of it almost constantly).

<p>1 - 1 2 3 Acid foods upset 2 - 1 2 3 Get chilled, often 3 - 1 2 3 "Lump" in throat 4 - 1 2 3 Dry mouth-eyes-nose 5 - 1 2 3 Pulse speeds after meal 6 - 1 2 3 Keyed up - fail to calm 7 - 1 2 3 Cuts heal slowly</p>	<p align="center">GROUP ONE</p> <p>8 - 1 2 3 Gag easily 9 - 1 2 3 Unable to relax; startles easily 10 - 1 2 3 Extremities cold, clammy 11 - 1 2 3 Strong light irritates 12 - 1 2 3 Urine amount reduced 13 - 1 2 3 Heart pounds after retiring 14 - 1 2 3 "Nervous" stomach</p>	<p>15 - 1 2 3 Appetite reduced 16 - 1 2 3 Cold sweats often 17 - 1 2 3 Fever easily raised 18 - 1 2 3 Neuralgia-like pains 19 - 1 2 3 Staring, blinks little 20 - 1 2 3 Sour stomach frequent</p>
<p>21 - 1 2 3 Joint stiffness after arising 22 - 1 2 3 Muscle-leg-toe cramps at night 23 - 1 2 3 "Butterfly" stomach, cramps 24 - 1 2 3 Eyes or nose watery 25 - 1 2 3 Eyes blink often 26 - 1 2 3 Eyelids swollen, puffy 27 - 1 2 3 Indigestion soon after meals 28 - 1 2 3 Always seems hungry; feels "lightheaded" often</p>	<p align="center">GROUP TWO</p> <p>29 - 1 2 3 Digestion rapid 30 - 1 2 3 Vomiting frequent 31 - 1 2 3 Hoarseness frequent 32 - 1 2 3 Breathing irregular 33 - 1 2 3 Pulse slow; feels "irregular" 34 - 1 2 3 Gagging reflex slow 35 - 1 2 3 Difficulty swallowing 36 - 1 2 3 Constipation, diarrhea alternating</p>	<p>37 - 1 2 3 "Slow starter" 38 - 1 2 3 Get "chilled" infrequently 39 - 1 2 3 Perspire easily 40 - 1 2 3 Circulation poor, sensitive to cold 41 - 1 2 3 Subject to colds, asthma, bronchitis</p>
<p>42 - 1 2 3 Eat when nervous 43 - 1 2 3 Excessive appetite 44 - 1 2 3 Hungry between meals 45 - 1 2 3 Irritable before meals 46 - 1 2 3 Get "shaky" if hungry 47 - 1 2 3 Fatigue, eating relieves 48 - 1 2 3 "Lightheaded" if meals delayed</p>	<p align="center">GROUP THREE</p> <p>49 - 1 2 3 Heart palpitates if meals missed or delayed 50 - 1 2 3 Afternoon headaches 51 - 1 2 3 Overeating sweets upsets 52 - 1 2 3 Awaken after few hours sleep - hard to get back to sleep</p>	<p>53 - 1 2 3 Crave candy or coffee in afternoons 54 - 1 2 3 Moods of depression - "blues" or melancholy 55 - 1 2 3 Abnormal craving for sweets or snacks</p>
<p>56 - 1 2 3 Hands and feet go to sleep easily, numbness 57 - 1 2 3 Sigh frequently, "air hunger" 58 - 1 2 3 Aware of "breathing heavily" 59 - 1 2 3 High altitude discomfort 60 - 1 2 3 Opens windows in closed room 61 - 1 2 3 Susceptible to colds and fevers 62 - 1 2 3 Afternoon "yawner"</p>	<p align="center">GROUP FOUR</p> <p>63 - 1 2 3 Get "drowsy" often 64 - 1 2 3 Swollen ankles worse at night 65 - 1 2 3 Muscle cramps, worse during exercise; get "charley horses" 66 - 1 2 3 Shortness of breath on exertion 67 - 1 2 3 Dull pain in chest or radiating into left arm, worse on exertion</p>	<p>68 - 1 2 3 Bruise easily, "black and blue" spots 69 - 1 2 3 Tendency to anemia 70 - 1 2 3 "Nose bleeds" frequent 71 - 1 2 3 Noises in head, or "ringing in ears" 72 - 1 2 3 Tension under the breastbone, or feeling of "tightness" worse on exertion</p>

<p>73 - 1 2 3 Dizziness 74 - 1 2 3 Dry Skin 75- 1 2 3 Burning Feet 76 - 1 2 3 Blurred vision 77 - 1 2 3 Itching skin and feet 78 - 1 2 3 Excessive falling hair 79 - 1 2 3 Frequent skin rashes 80 - 1 2 3 Bitter, metallic taste in mouth in mornings 81 - 1 2 3 Bowel movements painful or difficult</p>	<p style="text-align: center;">GROUP FIVE</p> <p>82 - 1 2 3 Worrier, feels insecure 83 - 1 2 3 Feeling queasy; headache over eyes 84 - 1 2 3 Greasy foods upset 85 - 1 2 3 Stools light-colored 86 - 1 2 3 Skin peels on foot soles 87 - 1 2 3 Pain between shoulder blades 88 - 1 2 3 Use laxatives 89 - 1 2 3 Stools alternate from soft to watery</p>	<p>90 - 1 2 3 History of gallbladder attacks or gallstones 91 - 1 2 3 Sneezing attacks 92 - 1 2 3 Dreaming, nightmare type bad dreams 93 - 1 2 3 Bad breath (halitosis) 94 - 1 2 3 Milk products cause distress 95 - 1 2 3 Sensitive to hot weather 96 - 1 2 3 Burning or itching anus 97 - 1 2 3 Crave sweets</p>
<p>98 - 1 2 3 Loss of taste for meat 99 - 1 2 3 Lower bowel gas several hours after eating 100 - 1 2 3 Burning stomach sensations, eating relieves</p>	<p style="text-align: center;">GROUP SIX</p> <p>101 - 1 2 3 Coated tongue 102 - 1 2 3 Pass large amounts of foul-smelling gas 103 - 1 2 3 Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.</p>	<p>104 - 1 2 3 Mucous colitis or "irritable bowel" 105 - 1 2 3 Gas shortly after eating 106 - 1 2 3 Stomach "bloating" after eating</p>
<p style="text-align: center;">(A)</p> <p>107 - 1 2 3 Insomnia 108 - 1 2 3 Nervousness 109- 1 2 3 Can't gain weight 110 - 1 2 3 Intolerance to heat 111 - 1 2 3 Highly emotional 112 - 1 2 3 Flush easily 113 - 1 2 3 Night sweats 114 - 1 2 3 Thin, moist skin 115 - 1 2 3 Inward trembling 116 - 1 2 3 Heart palpitates 117 - 1 2 3 Increased appetite without weight gain 118 - 1 2 3 Pulse fast at rest 119 - 1 2 3 Eyelids and face twitch 120 - 1 2 3 Irritable and restless 121 - 1 2 3 Can't work under pressure</p> <p style="text-align: center;">(B)</p> <p>122 - 1 2 3 Increase in weight 123 - 1 2 3 Decrease in appetite 124- 1 2 3 Fatigue easily 125 - 1 2 3 Ringing in ears 126 - 1 2 3 Sleepy during day 127 - 1 2 3 Sensitive to cold 128 - 1 2 3 Dry or scaly skin 129 - 1 2 3 Constipation 130 - 1 2 3 Mental sluggishness 131 - 1 2 3 Hair course, falls out 132 - 1 2 3 Headaches upon arising wear off during day 133 - 1 2 3 Slow pulse, below 65 134 - 1 2 3 Frequency of urination 135 - 1 2 3 Impaired hearing 136 - 1 2 3 Reduced initiative</p>	<p style="text-align: center;">GROUP SEVEN</p> <p style="text-align: center;">(C)</p> <p>137 - 1 2 3 Failing memory 138 - 1 2 3 Low blood pressure 139 - 1 2 3 Increased sex drive 140 - 1 2 3 Headaches, "splitting or rending" type 141 - 1 2 3 Decreased sugar tolerance</p> <p style="text-align: center;">(D)</p> <p>142 - 1 2 3 Abnormal thirst 143 - 1 2 3 Bloating of abdomen 144 - 1 2 3 Weight gain around hips or waist 145 - 1 2 3 Sex drive reduced or lacking 146 - 1 2 3 Tendency to ulcers, colitis 147 - 1 2 3 Increased sugar tolerance 148 - 1 2 3 Women: menstrual disorders 149 - 1 2 3 Young girls: lack of menstrual function</p>	<p style="text-align: center;">(E)</p> <p>150 - 1 2 3 Dizziness 151 - 1 2 3 Headaches 152- 1 2 3 Hot flashes 153 - 1 2 3 Increased blood pressure 154 - 1 2 3 Hair growth on face or body (female) 155 - 1 2 3 Sugar in urine (not diabetes) 156 - 1 2 3 Masculine tendencies (female) 157 - 1 2 3 Weakness, dizziness 158 - 1 2 3 Chronic fatigue 159 - 1 2 3 Low blood pressure 160 - 1 2 3 Nails weak, ridged 161 - 1 2 3 Tendency to hives 162 - 1 2 3 Arthritic tendencies 163 - 1 2 3 Perspiration increase 164 - 1 2 3 Bowel disorders 165 - 1 2 3 Poor circulation 166 - 1 2 3 Swollen ankles 167 - 1 2 3 Crave salt 168 - 1 2 3 Brown spots or bronzing of skin 169 - 1 2 3 Allergies - tendency to asthma 170 - 1 2 3 Weakness after colds, influenza 171 - 1 2 3 Exhaustion - muscular and nervous 172 - 1 2 3 Respiratory disorders</p>

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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