Great Wall Chinese Medicine and Acupuncture
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NEW PATIENT REGISTRATION FORM

Patient Information

Patient's Name: (Last)	(First)	(Middle)	Today's Date:
Is this your legal name? Yes ☐ No ☐ *If not, what is your legal name?*			Sex: M ◯ F ◯
Social Security Number (optional):		Marital Status: Si ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐	
Birth Date: Age:	Personal Phone:		Work Phone:
Street Address:		Email Address:	
City:	State:	Zip Code:	Employer:
How were you referred to our clinic and why did you choose us?		WeChat ID:	Occupation: Full-time ◯ Part-time ◯ Retired ◯ Unemployed ◯

Emergency Contact

Emergency Contact's Name:	Relationship:	Phone Number:

Share Your Story

Are you interested in giving a testimonial upon feeling better? Yes ◯ No ◯ Maybe ◯
If yes, check all that applies: Written Testimonial ☐ Online (Yelp, Google, Yahoo, Facebook) ☐ Video ☐

Personal Health History

Childhood illness: Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Other:

List any and all medical problems and the year that you were diagnosed with:

Communicable Disease_____ Bleeding Disorder _____
Cancer _____ Depression _____
Diabetes _____ Heart Problems _____
High Blood Pressure _____ Thyroid Problems _____
Others: _____

Have you had any surgeries (pace-maker, replacement, plastic surgery, etc.)?

Year: Reason for surgery: Year: Reason for surgery:
Year: Reason for surgery: Year: Reason for surgery:

Other hospitalizations?

Year: Reason: Year: Reason:
Year: Reason: Year: Reason:

List any medications, prescriptions, vitamins, or over-the-counter items you are taking or have taken in the past 3 months and their purpose:

Are you allergic to any medications? Yes ◯ No ◯
If yes, please list them.

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Women Only

Menstruation Cycle: Always comes early ☐ Always comes late ☐ Irregular ☐ On time ☐

Menstruation Amount: Heavy ☐ Spotty ☐ Normal ☐

Menstruation Color: Dark red or bright red ☐ Pale blood ☐ Purple or blackish ☐

Menstruation Quality: Congealed blood with clots ☐ Water blood ☐ Turbid blood/Cloudy ☐

Menstruation Pain: Before the periods ☐ After the periods ☐ During the periods ☐

Discharge Color: White ☐ Yellow ☐ Greenish ☐ Red & White ☐ Yellow/pus & blood ☐

Discharge Consistency: Watery ☐ Thick ☐ Normal ☐ **Discharge Smell:** Fishy ☐ Leathery ☐ No smell ☐

Family Health History

Does your mother, father, grandparents, brothers, sisters, aunts, uncles, or children have any of the following? *If yes, who?*

Allergy _____ Bleeding Disorder _____

Cancer _____ Depression _____

Diabetes _____ Heart Problems _____

High Blood Pressure _____ Other _____

Health Habits and Personal Safety

Exercise Level: How often do you exercise: ____hrs/day, ____days/week. Do you stretch? Yes ◯ No ◯

Intensity Level: _____ (1-low to 10-high) What do you do for exercise? _____

Diet: Are you dieting? Yes ◯ No ◯ *If yes, are you on a physician prescribed medical diet? Yes ◯ No ◯*

# of meals you eat a day: _____ Salt intake: Low ◯ Med ◯ Hi ◯ Fat intake: low ◯ Med ◯ Hi ◯

Caffeine: None ☐ Coffee ☐ Tea ☐ Cola ☐ *How many times in a day do you drink it?*

Alcohol: Do you drink? Yes ◯ No ◯ *If yes, what kind?* _____ How many drinks per week? _____

Tobacco: Yes ◯ No ◯ How many: ____cigarettes/day; ____chew/day; ____pipe/day; ____Cigar/day.

# of years used: _____ *If you have quit, how long has it been?* _____ Smoke exposure? Yes ◯ No ◯

Drugs: Do you currently use recreational or street drugs? Yes ◯ No ◯

Have you ever used street drugs via injection with a needle? Yes ◯ No ◯

Sex: Are you sexually active? Yes ◯ No ◯ If yes, are you trying for pregnancy? Yes ◯ No ◯

If not trying for pregnancy, list methods of contraceptive used: _____

Living Situation: Do you live alone? Yes ◯ No ◯ Do you fall frequently? Yes ◯ No ◯

Are there pets at home? Yes ◯ No ◯ *If yes, what type?* _____

Read and Sign

By signing below, I acknowledge the above information is true to the best of my knowledge.

I understand that Great Wall Chinese Medicine (GWCM) does not participate with any health insurance companies, and does not bill any health insurance companies. If requested by patient GWCM can provide a bill that patients may submit directly to the insurance company, which in turn might reimburse patients directly. I also authorize GWCM or insurance company to release any information required processing my claims. Patients should contact their insurance company to find out what types of acupuncture services are covered under their policy. GWCM will collect payment when services are rendered. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in-full and immediately upon presentation of appropriate statement. I understand and agree that full payment, paid in cash or by credit cards, is required at time services are rendered.

_____

Patient (parent/guardian) Signature Print Name Date

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Informed Consent and Disclosure

A copy of government-issued photo ID (driver license, passport, etc.) is required for medical records and HIPAA purposes.

Insurance payments issued to GWCM and refunded to patients are subject to a fee of 5%.

Additional agreement and/or forms are required if treatments are related to *(select one)*: ☐ Motor Vehicle Accident ☐ Worker's Compensation ☐ Health Insurance.

All information requires annual update.

I hereby request and consent to acupuncture treatment and/or herbal supplement recommendations for me provided by Great Wall Chinese Medicine (GWCM). I understand that GWCM will explain all known risks and complications, and I wish to rely on GWCM to exercise judgment during the course of the procedure, which GWCM determines is in my best interest. I may request another person of my choice to be present in the treatment room during the treatment. I agree to GWCM's use of this treatment (if indicated).

**Please read and initial each of the following items.*

_____**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.) Each patient is different, with focus on energy stagnation, depending on the person. 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 condition(s) 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.

_____**Indirect Moxibustion** requires burning an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of skin contact and mild burns exists. GWCM does not allow direct moxibustion where material contacts the skin. Please refer to https://www.chinesedrs.com/new2/after-treatment for after-treatment care.

_____**Cupping** involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction and slight burning or blistering due to the heat involved in the technique.

_____**Scraping/GuaSha** involves scraping over a small area by using a smooth-edged instrument. There is a possibility that local bruising is likely to occur at the site where GuaSha is performed.

_____**Tapping, Plum Blossom, Bleeding, Pricking** all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment site are a likely occurrence. Only single-use needles are used in these procedures.

_____**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 you are pregnant or have scar tissues, diabetes or hernia, please inform therapists and doctors to avoid direct infrared lighting to stomach or too closed to skin.

I have read, or have had read to me, the above consent and information, and am aware of that I have the opportunity to ask questions with GWCM. I consent to treatments that involves the above procedures for my present condition(s) 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 visit https://www.chinesedrs.com/new2/after-treatment for after-treatment care and may contact GWCM at anytime if I still have concerns or questions.

Patient (parent/guardian) Signature Print Name Date

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

Standard Authorization of Use and Disclosure of Protected Health Information

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

☐ Medical Records ☐ Billing ☐ Appointments

☐ Other: _____

Persons Authorized to Disclose Information - 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 or Legally Authorized Individual Signature Date

_____

Print Patient's Full Name Date

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Cancellation Policy

All appointments must be canceled 24 hours in advance.

1. A $60 charge will be added to patient account if canceled within 24 hours of appointment.
2. If a patient consecutively sets & cancels 3 appointment without attending, a $90 charge will be incurred.
3. If a patient does not call or show up for their appointment a $120 charge will be incurred.

*All charges must be paid before treatment will be continued.

*Great Wall reserves the right to amend these policies or make special considerations. Supporting documents may be required for special considerations.

Package Policy

Packages are purchased and discounted in sessions of 5 and 10. If a patient chooses to cancel an on- going, pre-paid package, they will be charged either the value of the closest matched package or full price for each session attended (e.g. If a 10 holistic package is purchased at a discount of $130/visit and only 3 visits are attended before cancellation, the patient will be charged full price of $145 for 3 visits and refunded the remainder. If 5 visits were attended before cancellation, the patient will be charged the price of a 5 package for $135/visit with the remainder refunded).

All packages must be used within 1 year of purchase.

Special circumstances may be approved

Packages are transferable to another person upon approved request, however, treatment value must be matched (e.g. If new patient receives treatment $180 above package cost $130 for the new patient visit, they must pay the remainder of the new patient visit cost $50.)

All refunds will be given in the manner in which they are received. Cash will be refunded via check.

Payment Methods Accepted

GWCM accepts payments through credit card, cash, check, Health Saving Accounts (HSA) and Flexible Spending Accounts (FSA). For a check that is bounced, a $25 fee will be collected.

Great Wall Chinese Medicine reserves the right to refuse service and treatment to anyone at any time.
Additionally, Great Wall Chinese Medicine reserves the right to cancel on-going, pre-paid treatments & will only refund treatments not received. Great Wall Chinese Medicine will collect payment for all services rendered.

Patient (parent/guardian) Signature | Print Name | Date

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Patient Sign In
Appointment Time: _____
Check-in Time: _____
Today's Date: _____

Patient Self-Assessment

Patient's Name: (Last) (First) (MI)

Answer the following questions according to your average condition for the past few days or since last treatment.

Overall well-being: ____ (1-low to 10-high) | Energy level: ____ (1-low to 10-high) | Stress level: ____ (1-low to 10-high)

Mood: Optimistic ☐ Happy ☐ Calm ☐ Agitated ☐ Anxious ☐ Depressed ☐ Anger ☐

Sleep: ____ hrs; wake up ____ times due to: Pain ☐ Urination ☐ Dreams ☐ Sweat ☐ | Night sweats: Yes ◯ No ◯

Ringing in ears: Yes ◯ No ◯ | Dizziness: Yes ◯ No ◯ | Bloating: Yes ◯ No ◯ | Exercise: ____hours/week

Appetite: Easily hungry ☐ Loss of appetite ☐ Excessive eating ☐ Crave salty ☐ Crave sweets ☐ Sleepy after meal ☐ Normal ☐

Bowel movement: ____ times/day; shape: Solid ☐ Loose ☐ Dry ☐ Diarrhea ☐ Constipation ☐

Urination: ____ times/day; condition: Dark color ☐ Frequent ☐ Leaky ☐ Foamy ☐ Normal ☐ | Last menstrual period start and end date:

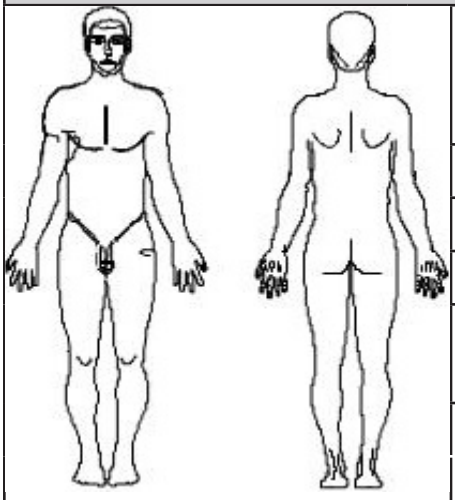
Chief complaints:

Medication/drug dose use (more/less), new symptoms, lab test, surgery or other doctor's visit:

Section A - Programs

1. Weight Loss ☐/Diabetes ☐/Pre-Diabetes ☐ 2. Drug Addiction ☐ /Smoking Cessation ☐/Alcohol Dependency ☐
3. Infertility ☐/Impotence ☐/Low libido ☐ 4. TCM Consultation ☐ /Executive Physical Examination ☐
5. Pain Management (complete Section B) ☐ 6. Longevity ☐/Rejuvenation ☐/Wellness Program ☐ 7. N/A ☐

Section B - Pain Management



Please list your symptoms below and the relative pain intensity range (0-10) for each symptoms. 0 (no pain) - 10 (unbearable). Example: Low back pain - 4 to 6

1) _____ 2) _____

Time and cause of increase pain (check all that apply): Morning ☐ Night ☐
Weather ☐ Lack of Sleep ☐ Mood Swings ☐ Motion ☐ *Explain:*

Other notes: _____

Please mark on the diagram above the following symbols as they relate to your symptoms: SS=spasms ST=stiffness DP=dull pain SP=sharp pain SH=shooting pain TI=tingling NU=numbness O=other

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 (parent/guardian) Signature: _____ Date: _____

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