Soaring Crane Acupuncture, LLC
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Successful healthcare and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. Please take the time to fill out the questionnaire carefully.

Patient Information Form

Name _____ SSN _____
(Last) (First) (Middle) (Strictly Confidential)
Home Address _____
(Street, Apt #) (City) (State) (Zip)
Home Phone (_____) _____ Work (_____) _____ Cell (_____) _____

Birth Date _____ /_____ /_____ Age _____ Gender F ☐ M ☐ Marital Status: _____

Best Number to Contact You (_____) _____ Weight _____ Height _____
Email _____ What is your occupation? _____

Employer's Name _____ Address _____

Emergency Contact _____ Relationship to you _____ Phone # (___) _____

Insurance Information

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

Insurance Company: _____ Insured's ID #_____
SS# _____Group # _____ Birth Date: _____ / _____ / _____

As a service to our patients, Soaring Crane Acupuncture will submit the 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 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 the insurance does not pay.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Soaring Crane Acupuncture. I also authorize my insurance company to release any information required to process claims. I agree to be responsible for payment of service in the event my insurance company does not 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

Name _____ Date of Birth _____

How did you find our clinic, or whom may we thank for referring you?_____

Who is your primary care physician if different?_____

What if any contagious conditions do you have at this time?_____

Have you tried acupuncture before? ☐ Yes ☐ No For What Condition?_____

_____

Please list any injuries, traumas, surgeries, or hospitalization you have had:_____

What medications do you take and for what? _____

_____

Please list over the counter medications you take:_____

Vitamins/ Supplements/Herbal Remedies you take: _____

_____

Any drug, or food allergies/ intolerances? If yes please list:_____

Family Medical History: Please check those that apply to parents, aunts or uncles, and siblings.

☐ Heart Disease	☐ High Blood Pr.	☐ Stoke	☐ Cancer	☐ HIV ☐ Hep.C
☐ Atherosclerosis	☐ Diabetes	☐ Alzheimer's	☐ Seizures	☐ Thyroid Disease

Your Medical History: Please check those that apply.

☐ AIDS/ HIV	☐ Asthma	☐ Atherosclerosis	☐ Anemia
☐ Cancer	☐ Gastritis/Ulcers	☐ Chronic Pain/Fibromyalgia	☐ Heart Disease
☐ Auto Immune Dz.	☐ High/Low Blood Pr.	☐ Hypo/Hyperglycemia	☐ Lyme Disease
☐ Diabetes	☐ IBS/Crohn's/UC	☐ Sexually Transmitted Dz.	☐ Head Injury
☐ Arthritis	☐ Thyroid Imbalances	☐ Elevated Cholesterol	☐ ADD/ ADHD
☐ Stroke	☐ Kidney Dz/Stones	☐ Liver/Gall Bladder Dz.	☐ Epilepsy
☐ Bleeding Disorders	☐ Emphysema	☐ Weight Loss or Gain	☐ Alcoholism
☐ Hepatitis B or C	☐ Raynaud's Dz.	☐ Prostate Enlargement	☐ Other

Lifestyle:
Do you exercise? ☐ Yes ☐ No How many times per week?_____ Types of exercise:_____

Describe your typical daily diet:

Breakfast _____

Lunch _____

Dinner_____

Snacks_____

Name _____ Date of Birth _____

How much water do you drink a daily?_____ How much caffeine do you drink daily? _____ coffee _____ tea ____ soda

Are you a smoker? ☐ Yes ☐ No Number of Packs per/day_____ Former smoker? ☐ Yes ☐ No

Do you smoke Marijuana? ☐ Yes ☐ No How often? _____ For what purpose? _____

How often do you consume alcoholic beverages? _____ What type? _____ How much?_____

Do you have sleep problems? ☐ Yes ☐ No Do you wake during the night? ☐ Yes ☐ No What time?_____

Are you able to return to sleep? ☐ Yes ☐ No

Please rank your stress level? High ☐ Moderate ☐ Low ☐

What do you do for stress reduction? _____

What brings you to our clinic today?

Reason(s) for Today's Visit? _____

_____

How and when did this condition(s) begin?_____

_____

Have you received treatment for this condition before? ☐ Yes ☐ No By whom:_____

What was the diagnosis? _____

What were the results of treatment? _____

_____

Has the condition been getting: ☐ better ☐ worse or ☐ staying the same?

How would you classify your condition: ☐ Minor ☐ Moderate ☐ Severe

How does the condition impair your daily activity? _____

_____

What improves your symptoms? _____

_____

What makes them worse? _____

_____

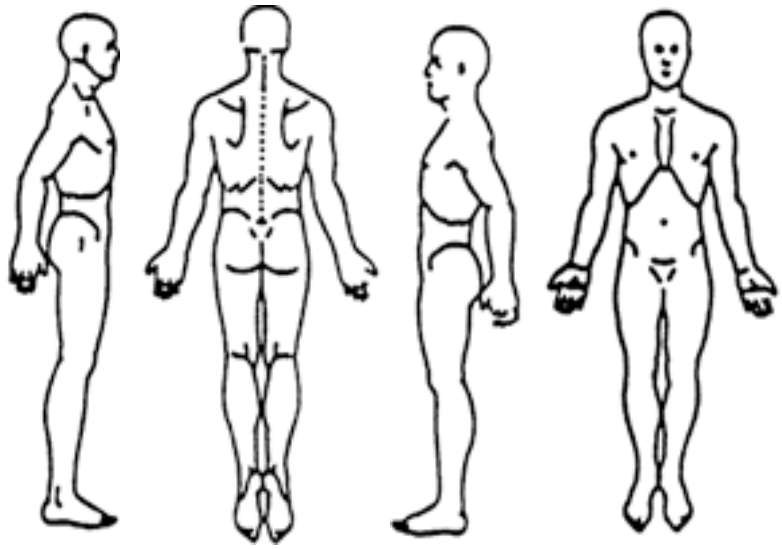
Name _____ Date of Birth _____

Please list you're the main health problems you would like to address in order of importance:

1._____ 2._____

3._____ 4. _____

Please mark all areas of pain on the diagram:



(Please check all that apply)

c= Current p= Past o= Occasionally

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c ☐/p ☐/o ☐ Sciatica	c ☐/p ☐/o ☐ Herniated Disc	c ☐/p ☐/o ☐ Low Back pain
c ☐/p ☐/o ☐ Upper Back pain	c ☐/p ☐/o ☐ Radiating pain	c ☐/p ☐/o ☐ Shoulder pain
c ☐/p ☐/o ☐ Rib pain	c ☐/p ☐/o ☐ Frozen Shoulder	c ☐/p ☐/o ☐ Rotator Cuff
c ☐/p ☐/o ☐ Carpal Tunnel	c ☐/p ☐/o ☐ Trigger Thumb	c ☐/p ☐/o ☐ Jaw Pain
c ☐/p ☐/o ☐ Elbow pain	c ☐/p ☐/o ☐ Knee pain	c ☐/p ☐/o ☐ Thigh-Leg pain
c ☐/p ☐/o ☐ Hip pain	c ☐/p ☐/o ☐ Bursitis	c ☐/p ☐/o ☐ Plantar Fasciitis
c ☐/p ☐/o ☐ Hand/Wrist pain	c ☐/p ☐/o ☐ Ankle Sprain	c ☐/p ☐/o ☐ Whiplash Inj.

Name _____ Date of Birth _____

Missed Appointments

When a patient schedules an appointment, time is reserved for that patient alone. If you are unable to keep an appointment, it is our policy that you give us 48-hour notice so that we may schedule someone else in that time period. When an appointment is not kept our time is lost.

Unless canceled at least 48 hours in advance, we will need to charge a fee of $100.00 for the missed appointment.

NOTE: if we can fill your appointment time, we may choose not to charge you at all, so please give us notice of your schedule change as soon as possible.

Signature_____Date_____

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

Soaring Crane Acupuncture is dedicated to preserving your privacy and your personal health information. This Notice describes how your medical information may be used and disclosed and how you can get access to this information, so please review it carefully.

You have the right to request restrictions on certain uses and disclosure of your health information. If services are paid in full by cash, you may restrict that information to any insurer for purposes other than for treatment.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location, other than the usual method of communication or delivery, upon your request.

You have a right to request that we amend your protected health information. Please be advised that we may not be required to agree to amend your protected health information. If you request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with a denial.

You have a right to receive an accounting of disclosures of your protected health information made by Soaring Crane Acupuncture. We must have your written consent before we use or disclose to others your medical information. We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

We have 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-hang side of this page indicated the date of the most current NOTICE in effect. You can also view it on our website at http://www.soaringcraneacupuncture.com/patient-forms/

If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact Soaring Crane Acupuncture. You may also send a written complaint to the US Department of Health and Human Services.

_____ _____
Patient Signature/Guardian Date

_____ _____
Printed Name