Winnie Dong, LAc
9735 SW Shady Lane, Suite 306
Tigard, OR 97223
Tel/Txt: (503) 343-9828

Embrace health, celebrate life!

New Patient Information

Name:_____________________________ DOB:_______________Today's Date _________________

Occupation ___________________________ If child, Parent Name________________________

Address____

City ______________________________________ State ______________ Zip code ________________

Telephone # (home)___________________ Telephone # (cell) ___________________

Email Address_____________________________ Employer _____________________________________

Emergency Contact __________________ Relationship_____________ Telephone #________________

If no, when and where did you last receive medical or health care and for what reason?

____

Height:_____________ Weight:________________ Blood Pressure(if known):_____________

Major Medical History (Major Surgery, Trauma, Auto Accident, Hospitalization, Premature Birth)

____

Please list any prescription medications, over the counter medications, vitamins, or supplements you are currently taking or have taken within the past 2 months and their dosage:

1)________________________________ 2)_______________________________
3)________________________________ 4)_______________________________
5)________________________________ 6)_______________________________

Please list your major allergies including food, chemicals, environmental and drugs.

Major Family Health History

____

Please circle any of the conditions below that apply:

Tendency to faint Hepatitis AIDS High Blood Pressure Heart Disease Surgery

Nervous Presently exhausted Presently Hungary

** Please come to acupuncture appointment with food in the stomach and best eaten at least one hour prior.

Winnie Dong, LAc
9735 SW Shady Lane, Suite 306
Tigard, OR 97223
Tel/Txt: (503) 343-9828

Patient Name:______________________ DOB:________________Today's Date _________________

What are your most important health concerns? List in order of importance.

1) _________________________________ Onset ______________________________

2) __________________________________ Onset______________________________

For the condition listed in 1), how did it develop? _______________________________________

What makes it better? _______________________What makes it worse? _______________________

Have you received treatment for this condition? YES / NO

If yes, when and by whom? ____

What was the diagnosis?______________________Has the condition been getting better/worse/ same?

For the condition listed in 2), how did it develop____

What makes it better? _______________________What makes it worse? _______________________

Have you received treatment for this condition? YES/NO

If yes, when and by whom? ____

What was the diagnosis?_______________________Has the condition been getter better/worse/same?

Any concerns, doubts or fears regarding this treatment (if any)? _______________________________
Are there any foods you crave? ____

Habits (circle any): Cigarettes Coffee Tea Cola Alcohol Drugs Sugar Salt Other_____

Please rate your energy on the scale of 0 to 10, (10 being the most energy one can have) ____________

Please rate your stress level from 0 to 10 (10 being the most stressed you have ever been). __________

What are your sources of stress?____

Do you tend towards any state, such as: Worry? Depression? Fear? Frustration? Anger?

Do you exercise? YES NO What and how often?____

Is there anything else than you would like me to know?______________________________________

Signature (Patient or Guardian):__________________________ Date: ___________________

WyEast Acupuncture & Wellness

Winnie Dong, LAc
9735 SW Shady Lane, Suite 306
Tigard, OR 97223
Tel/Txt: (503) 343-9828

Embrace health, celebrate life!

CHECK ANY CONDITION EXPERIENCED IN THE LAST YEAR

Name:______________________________**DOB:** ______________**Date:**_________________

GENERAL SYMPTIONS
Tremors______
Headaches______
Night Sweats____
Fainting_______
Dizziness______
Convulsions______
Insomnia_______
Poor memory______
Fatigue_______
Nervousness/Anxiety______
Depression_______
Loss of weight_____
Numbness/tingling/pain_____

EYES, EARS, NOSE, THROAT
Poor vision______
Blurred vision____
Dry eyes______
Blood shot eyes____
Loss of hearing_____
Ear ache_____
Ringing in ears______
Nose bleeds______
Nasal congestion_____
Nasal drainage______
Sinus infection______
Ear Infection_______
Allergies_______
Sore throat_____
Hoarseness_____
Difficulty swallowing______
Tonsillitis______
Enlarged thyroid_______
Enlarged glands_______

SKIN
Rashes______
Psoriasis_____
Dry skin______
Bruises easily____
Skin cancer_____
Acne_____
Eczema______

RESPIRATORY
Frequent colds or flu______
Chronic cough_______
Difficulty breathing____
Asthma______
Wheezing______
Bronchitis_______
Chest pain______
Spitting up blood_______

CARDIOVASCULAR
High blood pressure_____
Low blood pressure_____
Rapid heartbeat______
Slow heart beat______
Pain over heart______
Previous heart attack_____
Arterial blockage______
Swelling of ankles_____
Poor circulation______
Cold hands & feet_____
Paralytic circulation_____
Varicose veins______

MUSCLES & JOINTS
Jaw pain______
Neck pain_____
Back pain______
Hernia_______
Spinal curvature____
Swollen joints______
Painful joints_______
Arthritis______
Sciatica______
Weak muscles_____
Tendonitis_______
Carpal tunnel syndrome____

GENITOURINARY
Bladder infection_______
Kidney infection or stones_____
Painful or burning urination____
Blood in urine______
Night urination_____
Inability to control urine_____

GASTROINTESTINAL
Poor appetite______
Excessive hunger____
Hypoglycemia______
Belching_______
Nausea________
Flatulence______
Indigestion______
Blood in stool_____
Acid Reflux______
Vomiting_______
Stomach pain_____
Irritable bowel syndrome___
Constipation______
Hemorrhoids_______
Colitis______
Gallstones________
Gallbladder surgery____
Weight problems____

FEMALE
Painful menstrual period__
Excessive blood flow____
Blood clots______
Irregular cycles_____
Cramps or black ache___
Vaginal pain______
Vaginal discharge_____
Breast swelling_____
Lumps in breast______
Uterine fibroids_____
Pregnancy complications__
Menopausal symptoms___
Hot flashes_____
Reduced sexual energy___
Skin eruptions_____

MALE
Pain in genitals_______
Reduced sexual energy___
Premature ejaculation____
Impotence______
Prostate Issue______
Genital sores/inflammation___

Winnie Dong, LAc
9735 SW Shady Lane, Suite 306
Tigard, OR 97223
Tel/Txt: (503) 343-9828

Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Material Medica by a licensed acupuncturist at WyEast Acupuncture & Wellness. I understand that acupuncturists practicing in the states of Oregon is not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners. The following is a brief description of healing modalities that may be used in your treatment. Please know that most side effects of Chinese Medicine are minor or infrequent.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and contact WyEast Acupuncture & Wellness as soon as possible.

Acupressure/Shiatsu/Tui-Na Massage: I understand that I may also be given acupressure/shiatsu/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms

Winnie Dong, LAc
9735 SW Shady Lane, Suite 306
Tigard, OR 97223
Tel/Txt: (503) 343-9828

Consent to Treatment - continue

existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation.

I give my permission and consent to treatment.

Signature: ______________________________ Date: _________________________________

Printed Name: ___________________________ Date of Birth: __________________________

Winnie Dong, LAc
9735 SW Shady Lane, Suite 306
Tigard, OR 97223
Tel/Txt: (503) 343-9828

OFFICE AND FINANCIAL POLICY

Thank you for choosing our clinic to serve your healthcare needs. We are committed to your treatment being successful. In order to continue to deliver high quality health care, it is important your account remain current. The following is a statement of our Office & financial policy, which we ask you to read and sign prior to treatment.

Insurance Patients: If you have insurance, we will process and submit claims to your insurance company. Payment is due within 60 days after the date of service. Within reason we will do everything possible to have your claims paid by insurance. However, your insurance policy is a contract between you and your insurance company. Insurances are selective with which services and supplies they will cover. This office cannot guarantee payment of your claim, nor accept responsibility for collecting or negotiating settlement on disputed claims.

Reductions or rejection of claims by your insurance company does not relieve the financial obligation you have incurred. Upon receipt of payment by your insurance company, you will be billed for any balance remaining on your account. These payments are due in our office 30 days after billing you, or a finance charge for rebilling will be applied.

Non-Insured Patients: Patients without insurance are expected to pay their bill at time of service.

Deductibles: If a patient has not yet met their annual insurance deductible, then full payment is due at the time of service until the deductible is met. These claims will be processed and submitted to your insurance company so that credit is applied toward your deductible.

Co-Payments: If your insurance coverage includes co-payments, these will be due at the time of service.

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 24 hour notice so that we may schedule someone else in that time period. When an appointment is not kept, our time is lost. **Unless cancelled at least 24 Hours in advance, we will charge $25 for missed appointments. Please help us serve you better by keeping scheduled appointments.**

Appropriate Conduct: Patients who show inappropriate conduct, non-or late payment of fees, or safety concerns may be denied treatment. Thank you for understanding our office and financial policy. I, the undersigned have read the Policy. I understand and agree to these policies.

Signature of patient/guardian:___________________________ Date: ____________________

Printed name of patient:_____________________________ DOB: ________________________

Winnie Dong, LAc
9735 SW Shady Lane, Suite 306
Tigard, OR 97223
Tel/Txt: (503) 343-9828

Embrace health, celebrate life!

Acknowledgement of Receipt of Notice

As required by the privacy regulations, I hereby acknowledge that I have been offered and/or received a current copy of WyEast Acupuncture & Wellness, LLC's (WAW) privacy policy.

As required by the privacy regulations, ____Winnie Dong____from WyEast Acupuncture & Wellness has explained the privacy policy to my satisfaction.

As required by the privacy regulations, I am aware that WAW has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

By way of signature, I provide WAW with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Notice of Privacy Practices.

________________________________ ________________________________

(signature) (date)

________________________________ ________________________________

(Print Name) (DOB)