THOMAS
ACUPUNCTURE & WELLNESS

Thomas Acupuncture & Wellness
Confidential Intake Form

Today's Date: ____/____/____

Patient Information

Name: _____ _____ **Date of Birth:** ____/____/____
Last Name First Name Gender: M ◯ F ◯ Age:

Height: _____ Weight: _____ Blood Pressure: _____ Heart Rate: _____

Address: (Street) _____

(City) _____ (State) _____ (Zip Code) _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Occupation: _____

Description of Major Complaints

1. Pain and discomfort #1: _____

How long have you had this condition? _____ Sudden? ☐ Gradual? ☐

Have you seen a physician for complaint #1? If yes, what diagnosis did you receive?

_____

1. Pain and discomfort #2: _____

How long have you had this condition? _____ Sudden? ☐ Gradual? ☐

Have you seen a physician for complaint #2? If yes, what diagnosis did you receive?

_____

3. Other #3: _____

How long have you had this condition? _____ Sudden? ☐ Gradual? ☐

Have you seen a physician for complaint #2? If yes, what diagnosis did you receive?

_____

Current Medications, Supplements and Herbs:

_____

_____

Allergies (to any medications, supplements, herbs or food):

_____

_____

Past Medical/Surgical History:

_____

Family Medical History: (Please note all major illnesses in your close family)

_____

_____

How much do you smoke?..... _____

How much alcohol do you drink?..... _____

How much coffee / soda / tea do you drink?..... _____

SYMPTOM LIST Please check any problem, disease, or symptom you have.

SKIN:

- ☐ acne
- ☐ dermatitis
- ☐ eczema
- ☐ fungal
- ☐ furuncles
- ☐ infections
- ☐ psoriasis
- ☐ rashes
- ☐ skin
- ☐ warts

HEART & VASCULAR:

- ☐ fast pulse (over 100 beats/min)
- ☐ palpitation
- ☐ irregular pulse
- ☐ chest pain
- ☐ dizziness
- ☐ migraine
- ☐ cold hands/cold feet
- ☐ red face
- ☐ slow pulse(less than 60 beats/min)
- ☐ feeling of pressure in the chest
- ☐ short of breath
- ☐ headache with nausea
- ☐ Raynaud's disease
- ☐ flushed face
- ☐ anemia
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ cold sweats
- ☐ feel dizzy or faint when standing up quickly or standing for a long time

GASTROINTESTINAL:

- ☐ constipation
- ☐ diarrhea
- ☐ no appetite
- ☐ stomach pain
- ☐ indigestion
- ☐ heartburn
- ☐ intestinal gas
- ☐ belching
- ☐ ulcer
- ☐ gastritis
- ☐ lack of stomach acid
- ☐ hemorrhoids
- ☐ ileocecal valve spasm
- ☐ peritonitis
- ☐ pancreatitis
- ☐ irritable bowel
- ☐ polyps
- ☐ GI tumors

RESPIRATORY: ☐ asthma ☐ bronchitis ☐ emphysema ☐ cough ☐ wheeze ☐ pneumonia ☐ lung abscess

HORMONAL IMBALANCE: ☐ low thyroid ☐ overactive thyroid ☐ diabetes ☐ hypoglycemia ☐ blood sugar

*Other hormone imbalance:

Male: ☐ impotence ☐ premature ejaculation ☐ prostate gland problem ☐ vasectomy ☐ infertility

Female: ☐ menstrual problems ☐ cramping ☐ heavy/light/irregular periods ☐ PMS ☐ infertility ☐ emotional reactions ☐ menopause symptoms ☐ tubal ligation ☐ low libido

AUTOIMMUNE & INFLAMMATORY CONDITIONS:

- ☐ allergy
- ☐ alopecia(baldness)
- ☐ atopic dermatitis
- ☐ cellulitis
- ☐ colitis
- ☐ Crohn's disease
- ☐ food allergy
- ☐ Hashimoto's Disease (thyroid)
- ☐ low immunity
- ☐ neurodermatitis
- ☐ rheumatism
- ☐ sinus allergy
- ☐ systemic lupus erythematosus
- ☐ vulvitis

EFFECTS OF FOCAL INFECTIONS:

- ☐ arthritis
- ☐ constant slight fever
- ☐ ear infections
- ☐ easily catch cold or sore throat
- ☐ fibromyalgia
- ☐ glomerulonephritis
- ☐ ligaments pericarditis
- ☐ plantar fasciitis
- ☐ rheumatic disease
- ☐ rheumatic fever
- ☐ scarlet fever
- ☐ skin disease
- ☐ staphylococci infections
- ☐ streptococci infections
- ☐ swollen glands
- ☐ tendinitis
- ☐ Connective tissue or ligament diseases: Myofascial pain syndrome

EAR,NOSE & THROAT:

- ☐ deafness
- ☐ tinnitus(ringing in the ear)
- ☐ itchy ear
- ☐ ear pain
- ☐ frequent ear infections
- ☐ sinus headaches
- ☐ yellow mucus
- ☐ stuffy nose
- ☐ post-nasal-drip
- ☐ dry throat
- ☐ itchy throat
- ☐ sore throat
- ☐ constant sinus congestion
- ☐ streptococci throat infections

ORAL DISEASE:

- ☐ bleeding gums
- ☐ periodontitis
- ☐ dental abscess
- ☐ mumps
- ☐ TMJ
- ☐ toothaches without cavities
- ☐ stomatitis(inflammation of the mouth)

OTHERS (Please be specific):

GENERAL:

- ☐ difficulty concentrating on a task
- ☐ easily get carsick, seasick, or airsick
- ☐ emotional
- ☐ energetic all evening through midnight, but hate to wake up early in the morning
- ☐ exhaustion
- ☐ feel spacey
- ☐ insomnia
- ☐ long shower or bath makes you feel dizzy or faint
- ☐ moody in mornings
- ☐ never sweat
- ☐ no appetite for breakfast
- ☐ no energy
- ☐ psychosomatic weakness
- ☐ scattered minded
- ☐ unusual sweating(palm, sole or elsewhere)

SYSTEMS REVIEW / QUESTIONS

Tendency to be: ☐ Cold ☐ Warm ☐ Normal ☐ Hot ☐ Afternoon fever ☐ Aversion to cold, heat or bot

Sweating: ☐ Day ☐ Night ☐ Sometimes ☐ Always ☐ Whole body ☐ Head ☐ Neck ☐ Palms ☐ Soles

Pain: ☐ Back ☐ Shoulder ☐ Knee ☐ Neck ☐ Arm ☐ Hand ☐ Leg ☐ Foot **Headache (** ○ Frontal ○ Temporal ○ Vertex ○ Occipital **)**

Dizzy: ☐ Often ☐ Sometimes ☐ Rare ☐ Chest pressing ☐ Palpitation

Ears: ☐ Tinnitus ☐ Deafness ☐ Auditory ☐ Infection

Eyes: ☐ Normal ☐ Itch ☐ Tear ☐ Burning ☐ Pain ☐ Swelling ☐ Dryness ☐ Blurry ☐ Eyesights

Thirst: ☐ Cold Water ☐ Hot Water ☐ Room Temp ☐ No desire to drink

Sleep: ☐ Normal ☐ Difficulty falling asleep ☐ Easily awake ☐ Dreaming ☐ Insomnia ☐ Restless ☐ Sleepy

Apetite: ☐ Normal ☐ Poor ☐ Hyper ☐ Easily hunger ☐ No desire for food

Defecation: ☐ Normal ☐ Dry ☐ Loose ☐ Watery ☐ Bloody ☐ Painful ☐ Itchy
IBS _____/_____ Day ☐ Constipation ☐ Diarrhea ☐ Gas

Urination: ☐ Clear ☐ Light ☐ Yellow ☐ Dark Yellow ☐ Cloudy
☐ Frequent ☐ Difficulty ☐ Large amounts ☐ Scanty ☐ Pain ☐ Urgent
☐ Burning ☐ Dribbling ☐ Incontinence ☐ Wake up to urinate at night _____ times

Menses: Cycle/Frequency (_____ days) Period (_____ days) ☐ Menopause ☐ Pre-Menopause Symtoms
☐ Normal ☐ Excessive ☐ Scanty ☐ Red ☐ Dark Red ☐ Light ☐ Blood Clots
☐ PMS Pain? ☐ Before ☐ During ☐ After ☐ Taking Birth Control
Pregnant times _____ Miscarriage _____ Give Birth to _____ times

Energy Level: General (○ High ○ Normal ○ Low) Sexual (○ High ○ Normal ○ Low)

Emotion: ☐ Depression ☐ Anxiety ☐ Mood Swing

Male Issue:

DIETARY FOOD LIST

Please write down all the food list you have on a day in general.

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	DATE : / /
Breakfast (Morning)	
Lunch (Noon)	
Dinner (Evening)	
Any Snacks?	
Any Drinks?	

Note:	

THOMAS
ACUPUNCTURE & WELLNESS

Welcome to Thomas Acupuncture & Wellness Clinic. The following is a list of our procedures and office policies that will help you get better acquainted with us. If you have any questions, please speak with one of our staff members.

1. Please arrive at least 15 minutes before your appointment time so you have time to fill out new patient information forms.
2. If for some reason you have to cancel or reschedule an appointment, please call us at least 24 hours prior to your appointment time. You can leave a message on voice mail if you call after hours or on weekends.
3. Payment is expected in full at time of visit, unless other arrangements have been made prior to the services being rendered. This includes Co-pays.
4. If you have insurance, please keep in mind that your insurance is a contract between you and your insurance company. Our office cannot guarantee that your carrier will pay your claim. If your claim with your insurance company is denied, the obligation for the payment is the responsibility of the patient. Our office will not enter into a dispute with the insurance carrier over a claim. We will be happy to assist wherever possible.
5. We also provide receipt or invoice of service as a courtesy for your reimbursement, if needed. Please keep in mind that insurance companies all cover differently.

Please take time to read the following information, which provides you with some basic knowledge about acupuncture treatment.

If you experience dizziness, nausea, a cold sweat, shortness of breath, or faintness during treatment, please let us know immediately. This is known as needle shock, and while this occurrence is extremely rare, it helps to let us know if you experience any of these symptoms so that the needles can be removed. These symptoms go away immediately after needles are withdrawn, and are generally caused by anxiety when receiving acupuncture for the first time. Other possible side effects of acupuncture treatment may include local bruising, mild pain in the area treated, brief generalized fatigue, tingling or numbness.

Other important things to keep in mind regarding acupuncture treatment:

- While the needles are in place, do not change your position or move suddenly.
- Wear comfortable, loose clothing. We provide a paper gown during treatment if you want one.
- Maintain good personal hygiene.
- Avoid treatment when excessively fatigued, hungry, full or emotionally upset.
- We are unable to treat patients who are intoxicated and/or are abusing substances.

Everyone responds to treatment differently. Therefore, we can not guarantee the outcome of treatment. Some individuals experience total or partial relief of their pain or symptoms after the first few treatments. Others notice steady, gradual improvement. In some cases, no relief is felt at all until after several days go by. Occasionally, some people notice that their pain actually seems to be worse before it gets better. Let us know how you responded to the previous treatment at the time of your follow-up visits, so that your treatment plan can be adjusted accordingly. Depending on your condition and your goals for treatment, we may require a physician referral in order for you to continue treatment in our clinic. Clients are advised to consult a physician regarding the condition or conditions for which they are seeking acupuncture treatment. In addition, clients are responsible for seeking the advice and treatment of a physician, should their symptoms change for the worse, or should any new condition arise.

Please note that if you are having any side effects or concerns after treatment, in addition to calling us at 703-750-0577, you must call your primary care provider and/or visit the emergency room.

I have read and understand the above information.

_____ _____

Signature of Patient **Date**

THOMAS
ACUPUNCTURE & WELLNESS

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatment and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the practitioner/acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the practitioner/acupuncturist to exercise judgment during the course of treatment which the practitioner/acupuncturist thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand that the practitioner/acupuncturist and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient Signature **Date**

Indicate relationship if signing for patient : _____

THOMAS
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- NOTICE OF PRIVACY PRACTICE -

Thomas Acupuncture & Wellness, the "Practice," in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, the "Privacy Rule," and applicable state and federal law, is committed to protecting the privacy of your protected health information, or "PHI." The Practice understands that information about your health is personal. This Notice explains how your PHI may be reasonably used and disclosed to third parties as well as your rights regarding your PHI.

Respect for our patient privacy is highly valued at our clinic. We will protect the privacy of your health information that may reveal your identity and provide you with a copy of our notice, which describes the health information privacy procedures of our clinic when providing health care services.

➔ REQUIRED PERMISSION TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We will obtain a one-time general written consent to use and disclose your health information in order to treat you, obtain payment for that treatment and conduct the clinic operations. The general written consent will be obtained the first time we provide you with treatment or services. This general written consent is a broad permission that does not have to be repeated each time we provide treatment or services to you.

➔HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

USES AND DISCLOSURES

The Practice may use your PHI to provide you with treatment or to obtain payment for our services. The Practice may disclose your PHI as required or permitted by applicable law; in order to render or have rendered emergency treatment to you; for public health purposes; in cooperation with audits, inspections, licensures and other normal medical business requirements; in response to a court, grand jury, or administrative order, warrant, or subpoena; to alert a potential victim or victims or intending harm ("duty to warn"); to report a crime, a victim of a crime, or a person who committed a crime in emergency circumstances.

YOUR RIGHTS

You have the right to look at or get a copy of health information about you at the clinic. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

OUR LEGAL DUTY

We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice and seek your acknowledgement of receipt of this notice. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time.

COMPLAINTS

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact us at 703-750-0577 for any questions or complaints. You also may send a written complaint to the US Department of Health and Human Services.

ACKNOWLEDGEMENT

Your signature below is acknowledgement that you have been provided a copy of our Notice of Privacy Practices to read.

_____ _____

(Patient Signature) (Date Signed)

_____ _____

(Print Name) Patient client name, if signing as a parent or guardian

RECOMMENDATION FOR EXAMINATION BY A PHYSICIAN

Virginia law requires that this form be given to you if you do not have written evidence that you have received a diagnostic exam in the last six months from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry regarding the condition for which you are seeking treatment." *(Code of Virginia 54.I – 2956.9 .18 VAC 85-110-10)*

Thomas Acupuncture & Wellness recommends that _____
(Patient's **Full Name**)
be examined by a physician regarding the condition for which you are seeking acupuncture treatment.

I understand this recommendation.

_____ _____
Patient's Signature Date

Virginia law requires that I give this form to you if I do not have written evidence that you have received a diagnostic exam in the last six months from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry regarding the condition for which you are seeking treatment. (Code of Virginia §54.1-2956.9, 18 VAC 85-110-10).

Myung Chan Seo
Acupuncturist

_____
Date

WE, THE UNDERSIGNED, DO AFFIRM THAT THIS PATIENT HAS BEEN ADVISED BY MYUNG CHAN SEO TO CONSULT A PHYSICIAN REGARDING THE CONDITION FOR WHICH ACUPUNCTURE TREATMENT IS BEING SOUGHT.

THOMAS
ACUPUNCTURE & WELLNESS

LATE CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than **48 hours notice.** This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 48-hour notice, we are unable to offer that slot to other people.

Office appointments which are canceled with less than 48-hours notification and Late show up after 5:00 pm may be subject to a $70 fee.

Patients who do not show up for their appointment without a call to cancel an office appointment will be consider as **NO SHOW.**

Patients who NO SHOW may be subject to a $70 No-show fee.

Patients who No-show two (2) or more times in a 12month period, may be subject to a $140 fee for no-show office appointment.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fee in this instance may be waived but only management with approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Any questions about cancellation and no show fees should be done by contacting the office (703-750-0577).

Please sign that you have read, understand and agree to this Cancellation and No-Show Policy.

_____

Patient's name (Please print)

_____ _____

Signature of patient or Patient's Representative **Date Signed**

COVID-19 SCREENING FORM (Please Complete & Sign)

If you have been exposed to a communicable disease, you may spread the disease to the practitioner, staff, or other patients/visitors in the practice. Therefore, prior to each appointment, we will be asking the following questions to reduce the chances of transmission and ensure the safety of the practice and its visitors.

Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days? * ◯ Yes ◯ No

Have you or others accompanying you to today's appointment traveled outside of the state within the past 14 days? * ◯ Yes ◯ No

If "Yes" where did you travel? _____

Have you been tested for COVID-19 in the last 14 days? * ◯ No ◯ Yes, tested positive ◯ Yes, tested negative ◯ Yes, no results yet

Do you, others accompanying you today, or anyone you have been in contact with within the last 14 days have any of the following symptoms? (check if applicable)

☐ Fever (defined as above 100.4° F degrees)? *
☐ Chills or repeated shaking with chills? *
☐ Cough? *
☐ Sore throat? *
☐ New loss of taste or smell? *
☐ Shortness of breath or having trouble breathing? *
☐ Headache? *
☐ Body aches? *

Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days? * ◯ Yes ◯ No

If you selected YES or CHECK to any of the questions above please provide the approximate dates of your symptoms

Start Date _____ End Date _____

AGREE & ACKNOWLEDGE

- I understand that if I answer yes to any of these questions I may be asked to reschedule my appointment to a later date.
- I agree to notify the clinic if I become ill with COVID-19 symptoms or test positive for COVID-19 within 14 days of my appointment.
- I understand the clinic has a legal and ethical obligation to inform me if a staff person I had contact with tested positive for COVID-19 within 14 days of my appointment.

_____

Patient's name (Please print)

_____ _____

Signature of patient or Patient's Representative **Date Signed**