Nini Mai, L.Ac.

CONFIDENTIAL PATIENT INFORMATION FORM

Please let us know who referred you!_____

Name: _____ Home Phone: _____
LAST FIRST

E-Mail Address: _____ Cell Phone: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____ Drivers License: _____

Date of Birth: _____ Age: _____ Sex: M__ F__ T__ Place of Birth: _____

Marital Status: M__ S__ W__ D__ Spouse's Name: _____ # of Children: _____

Patient's Occupation: _____ Business Phone: _____

IN CASE OF EMERGENCY PLEASE NOTIFY: _____ Phone: _____

How would you like our office to contact you? Home # ____ Business # ____ Cell # ____ E-mail ____

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING YES OR NO

Do you have a tendency to faint?	Yes	No	Have you ever had Hepatitis?	Yes	No
Do you have a pacemaker?	Yes	No	Are you HIV positive?	Yes	No
Do you bleed for a long time?	Yes	No	Are you pregnant?	Yes	No

I DO HEREBY CERTIFY THAT THE PRECEEDING QUESTIONS HAVE BEEN ANSWERED TRUTHFULLY AND COMPLETELY TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature of Patient/Parent/Guardian

Date

Printed Name of Patient/Parent/Guardian

Relationship to Patient

Nini Mai, L.Ac.

TREATMENT INFORMATION

NATURE OF TREATMENT: Your treatment may include acupuncture, acupressure and/or Tui Na, moxibustion, cupping, Gua Sha, electrical stimulation, infrared heat, Chinese herbal therapy, therapeutic exercises, and dietary counseling based on the fundamentals of Chinese medicine.

- **ACUPUNCTURE:** Acupuncture as practiced in the state of California involves the insertion of sterile, single-use disposable needles into the body at various points eliciting a therapeutic effect. It has been shown to be relatively safe with little to no side-effects for most people. There are some uncommon potential risks however. These risks may include but are not limited to: discomfort during and after needle insertion, localized minor bruising or swelling, dizziness, fainting or nausea, allergic reactions to metals used in acupuncture needles, organ puncture, and nerve damage.

- **ACUPRESSURE AND TUI NA:** These methods of massage and physical manipulation utilize the points and channels of Chinese medical theory to treat the body without the use of needles. They can be used as an adjunctive therapy to acupuncture, or as stand-alone treatments according to the patient's needs.

- **MOXIBUSTION:** This treatment method involves the combustion of the therapeutic herb *Artemisia argyi,* commonly known as mugwort, either directly on or over various points of the body. This therapy produces warmth and heat in the area of application, and exhibits other therapeutic effects attributed to the herb as described in the Chinese materia medica. Burns and/or scarring are potentials risks of moxibustion.

- **CUPPING:** Fire is used to create a vacuum inside of sterilized glass cups that are then placed on the patient's skin. This vacuum has a mild to strong suctioning effect, depending on the nature of the treatment as determined by the acupuncturist. The most common side effects are reddening of the skin that may last for a few days and bruising.

- **GUA SHA:** Gua Sha is a form of dermal friction whereby a sterilized tool is used to scrape along the surface of the skin. In Chinese medical theory, it has a wide range of therapeutic uses. The most common side effects are reddening of the skin that may last for a few days and bruising.

- **ELECTRICAL STIMULATION:** Pairs of acupuncture needles are attached to a device that generates continuous electric pulses using small clips. These devices are used to adjust the frequency and intensity of the impulse being delivered, depending on the condition being treated. Please inform your acupuncturist if you have any implanted medical devices.

- **INFRARED HEAT:** A far-infrared heat lamp may be utilized during treatment to either enhance the treatment or for the comfort of the patient. Please inform your acupuncturist if you have any conditions that are exacerbated by the direct application of heat.

- **CHINESE HERBS:** Patients may be prescribed Chinese herbs as part of their treatment plan. Prescriptions generally consist of a combination of several herbs into a customized formula according to the patient's signs, symptoms, and overall constitution. The herbs that are recommended are traditionally considered safe in the practice of Chinese medicine within their prescribed dosages and methods of administration. Some possible side effects of taking herbs are nausea, gas, stomach upset, diarrhea, and tingling of the tongue. Patients must be sure to inform the acupuncturist of all the medications and supplements they are currently taking, as well as any known allergies.

- **THERAPEUTIC EXERCISES:** These include stretches, light exercise, meditation, and breathing exercises that the patient may be asked to perform at home.

SPECIAL SITUATIONS: Some herbs and acupuncture points are contra-indicated during pregnancy. Please notify the acupuncturist if you think you might be pregnant. Additionally, please inform us if you have severe bleeding disorders, if you are wearing a pacemaker or other electronic medical device, and if you have any known allergies to foods or medications.

USE OF DISPOSABLE NEEDLES: All needles are pre-sterilized, single-use needles made of surgical stainless steel. After treatment they are disposed of as medical waste; needles are never re-used. Very rarely, the acupuncturist may accidentally overlook a needle when removing them at the end of treatment. If you find that you have a needle with you after you leave the office, do not be alarmed. Simply remove the needle, place it in a hard container, and return it to the office on your next visit for proper disposal.

OUTCOME OF TREATMENT: The purpose of treatment is to resolve your complaint, i.e. the reason you are seeking treatment. Acupuncture is a health care service that is based on the pre-scientific Chinese system of medical theory. Diagnosis and treatment based on this theory are used to promote health and treat organic or functional disorders. This medical system utilizes a holistic approach, thereby treating the entire person and not singular symptoms. You may experience changes in your physical, mental, or emotional health that may seem unrelated to your complaint. If you have any questions or concerns regarding any changes or new symptoms that arise during the course of treatment, please inform your acupuncturist.

The World Health Organization lists multiple diseases for which acupuncture and its adjunctive therapies have been proved through controlled trials to be an effective treatment, as well as listing many more diseases for which acupuncture has been shown to have a therapeutic effect. However, we cannot guarantee the outcome of any course of treatment.

Nini Mai, L.Ac.

PATIENT INFORMED CONSENT

I hereby request and consent to the performance of acupuncture and other Chinese medicine procedures by the licensed acupuncturist **Vien-Phuong Nini Nguyen Mai** and/or other licensed acupuncturists who now or in the future treat me while working with Ms. Mai, or serves as a back-up for Ms. Mai in the event of a necessary cancellation, including those working in the same office, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, tui na, cupping, gua sha, electrical stimulation, infrared heat, herbs, therapeutic exercises, and dietary counseling. I have been informed of the potential risks associated with these treatment modalities.

I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

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

By voluntarily signing below I show that I have read, or have had read to me, this 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.

_____	Vien-Phuong Nini Nguyen Mai, L.Ac.
Print Name of Patient	**Print Name of Acupuncturist**
X_____	**X**_____
Signature of Patient or Representative	**Signature of Acupuncturist**
_____	_____
Print Name of Patient Representative	**Print Name of Witness or Translator**
_____	**X**_____
Date Consent Completed	**Signature of Witness or Translator**

Nini Mai, L.Ac.

PATIENT CARE FINANCIAL AGREEMENT

Dear Patient,

We want you to have a clear understanding of our policy concerning payment and insurance. Our office accepts cash, checks, Visa, MasterCard, American Express and Discover cards. Payment is expected at the time that services are rendered.

If you have an insurance policy that covers acupuncture, or have insurance but are unsure whether acupuncture is covered and would like to use your coverage for your visits, please provide us with the following information:

Insured's Name: _____ Insured's SSN: _____

Insured's ID Number: _____ Group # : _____

Name of Insurance Company: _____ Ins. Co. Phone: _____

Ins. Co. Address: _____

Since individual plans differ from person to person, you may be responsible for a deductible or co-pay. Our office will explain your payment responsibilities and options to you once we receive notice from your insurance company regarding your coverage. If this is your first visit to our office, we require payment for this visit at this time. This amount will be credited to you if warranted after verification of your insurance coverage.

In the event that you are unable to make it to your scheduled appointment, our office requires that you notify us of the cancellation **at least 24 hours in advance**. If an appointment is not cancelled within 24 hours of the scheduled time, you will be **charged for the treatment in full**.

By signing below, you acknowledge that you have read and understand the financial agreement policy as well as appointment cancellation policy of this office.

Thank you very much for your understanding.

Patient Name Patient Signature Date

Nini Mai, L.Ac.

CONFIDENTIAL PATIENT CONSULTATION AND HISTORY

Chief Complaint(s) *Please indicate how long you've had the condition(s).*

Other Complaint(s) *Please indicate how long you've had the condition(s).*

What kinds of treatments have you received? *Please indicate dates and duration of treatment.*

List any Hospitalizations & Surgeries **Date** **Place**

_____

_____

_____

_____

_____

_____

List medications being taken (include dose)

_____

_____

_____

_____

_____

_____

PATIENT NAME: DATE:

Please check if you have had (in the past twelve months):

General

- ☐ Anemia
- ☐ Bleed or Bruise Easily
- ☐ Poor Appetite
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fatigue
- ☐ Localized Weakness
- ☐ Tremors
- ☐ Poor Balance
- ☐ Sudden Energy Drop
- ☐ Fever
- ☐ Chills
- ☐ Cravings
- ☐ Peculiar Tastes or Smells
- ☐ Sweats
- ☐ Strong Thirst
- ☐ Poor Sleep Habits
- ☐ Frequent cold/flu

Skin and Hair

- ☐ Rashes
- ☐ Open sore
- ☐ Recent moles
- ☐ Itching
- ☐ Acne
- ☐ Loss of Hair
- ☐ Dandruff
- ☐ Hives
- ☐ Change in hair/skin texture
- ☐ Warts
- ☐ Nail Problems
- ☐ Psoriasis
- ☐ Dry skin
- ☐ Eczema

Head, Eyes, Ears, Nose and Throat

- ☐ Headache
- ☐ Migraine
- ☐ Dizziness/Vertigo
- ☐ Concussions
- ☐ Poor Vision
- ☐ Eye Strain
- ☐ Eye Pain
- ☐ Cataracts
- ☐ Night Blindness
- ☐ Color Blindness
- ☐ Ringing in ears
- ☐ Blurry Vision
- ☐ Earaches
- ☐ Sinus Problems
- ☐ Poor Hearing
- ☐ Spots in front of eyes
- ☐ Grinding Teeth
- ☐ Nose Bleeds
- ☐ Recurrent Sore Throats
- ☐ Nasal Congestion
- ☐ Hoarseness
- ☐ Facial Pain

Cardiovascular

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Coronary Heart Disease
- ☐ Pneumatic Heart Disease
- ☐ Difficulty in Breathing
- ☐ Palpitations
- ☐ Chest Pain
- ☐ Hardening of Arteries
- ☐ Irregular Heartbeat
- ☐ Varicose Veins
- ☐ Swelling of Hands/Feet
- ☐ Blood Clots
- ☐ Fainting
- ☐ Cold hands/feet

Respiratory

- ☐ Cough
- ☐ Coughing Blood
- ☐ Pain w/ deep breath
- ☐ Difficulty lying down
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Production of Phlegm
- ☐ Asthma
- ☐ Pleurisy
- ☐ Emphysema

Gastrointestinal

- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Gas
- ☐ Belching
- ☐ Bad Breath
- ☐ Blood in Stools
- ☐ Black Stools
- ☐ Abdominal Pain or Cramps
- ☐ Rectal Pain
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Chronic Laxative Use
- ☐ Acid Reflux
- ☐ Ulcer
- ☐ Colitis
- ☐ Diverticulitis

Genitourinary

- ☐ Bed Wetting
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Kidney Infections / Stones
- ☐ Painful Urination
- ☐ Bladder Infections
- ☐ Genital Herpes
- ☐ Venereal Disease
- ☐ Prostate Problems
- ☐ Cystitis
- ☐ Incontinence

PATIENT NAME: DATE:

Pregnancy and Gynecology

____ Number of Pregnancies
____ Number of Miscarriages
____ Number of Abortions
____ Number of Births
____ Age at 1st Menstruation
____ Time between Menstruation
____ Duration of Menstruation
____ First Date of Last Menstruation
☐ Irregular Periods
☐ Painful Periods/Cramps
☐ Clots
☐ Heavy Flow
☐ Light Flow
☐ Frequent changes in emotion
☐ Current Use of Birth Control
____ Duration of Use
☐ Past Use of Birth Control
____ Duration of Use
☐ Vaginal Sores
☐ Vaginal Discharge
☐ Breast Lumps
☐ Endometriosis
☐ Uterine Fibroids
☐ Ovarian Cysts
☐ Hot Flash/Night Sweats
☐ Urinary Tract Infections

Musculoskeletal

☐ Neck Pain
☐ Back Pain
☐ Shoulder Pain
☐ Elbow Pain
☐ Hand/Wrist Pain
☐ Hip Pain
☐ Knee Pain
☐ Foot/Ankle Pain
☐ Muscle Pains
☐ Muscle Weakness
☐ Muscle Spasms

Neuropsychological

☐ Seizures
☐ Dizziness
☐ Loss of Balance
☐ Areas of Numbness
☐ Lack of Coordination
☐ Poor Memory
☐ Concussion
☐ Depression
☐ Anxiety
☐ Bad Temper
☐ Easily susceptible to stress
☐ Difficulty Concentrating

Are you allergic to any of the following? (If yes, please specify)

☐ Medicine _____
☐ Food _____
☐ Herbs _____
☐ Others _____

Social History

	No	Yes	When Started	When Stopped	Amount (per week)
Coffee	___	___	_____	_____	_____
Tea	___	___	_____	_____	_____
Alcohol	___	___	_____	_____	_____
Tobacco	___	___	_____	_____	_____
Other	___	___	_____	_____	_____

Family History (please include the relation)

☐ Migraines _____
☐ Stroke _____
☐ Heart Disease _____
☐ High Blood Pressure _____
☐ Allergies _____
☐ Mental Illness _____
☐ Asthma _____
☐ Gall Stones _____
☐ Arthritis _____
☐ Cancer _____
☐ Diabetes _____
☐ Thyroid Disease _____
☐ Glaucoma _____
☐ Epilepsy _____

PATIENT NAME: DATE:

Physical Activity

Are there any activities that aggravate your complaint(s) or symptoms?

_____
_____
_____

Do you have an exercise regimen you like to practice? Please describe

_____
_____
_____

How often do you exercise?

- ☐ No regular exercise at the moment
- ☐ 1-2 times a week
- ☐ 2-4 times a week
- ☐ More than 4 times a week

Nutrition (Please choose one of the following)

☐ I am satisfied with my current diet and eating habits.
☐ I would like to change my current diet and eating habits.

Comments

Please tell us of any other problems you would like to discuss:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PATIENT NAME: DATE: