

Date \_\_\_\_\_

**PATIENT CONFIDENTIAL INFORMATION (PLEASE PRINT)**

Patient \_\_\_\_\_ Social Security # \_\_\_\_\_  
First Name Last Name Initial

Home Phone(\_\_\_\_\_) \_\_\_\_\_ Cell Phone(\_\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Separated  Divorced  Widowed

Occupation \_\_\_\_\_ Business Phone(\_\_\_\_\_) \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

What is your illness/injury? \_\_\_\_\_

Have you seen any other doctor about this condition?  Yes  No If yes, when? \_\_\_\_\_

Who is your physician? Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Is your condition related to employment (current or previous)?  Yes  No

Employer's Name \_\_\_\_\_

Is your condition related to auto accident?  Yes  No If yes, when? \_\_\_\_\_

Other accident?  Yes  No Please describe: \_\_\_\_\_

FOR FEMALES: Are you pregnant?  Yes  No If yes, for how long? \_\_\_\_\_

FOR MINORS: parent's name and date of birth \_\_\_\_\_

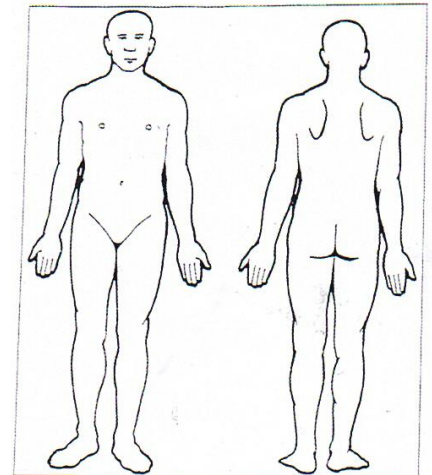
In case of emergency, call:  
 Phone(\_\_\_\_\_) \_\_\_\_\_  
 Name \_\_\_\_\_  
 Relationship to patient \_\_\_\_\_

**FINANCIAL ARRANGEMENTS**  
 How do you plan to handle your account?  
 Cash  Check  Visa/Master  AmEx

**INSURANCE INFORMATION**  
 Do you have personal, group health  
 or accident insurance?  Yes  No

If yes, please have the office make a copy  
 of your insurance card.

Please mark the  
 locations of pain or  
 discomfort.



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*Please complete the following as accurately as possible.*

<ul style="list-style-type: none"><li><input type="checkbox"/> epstein barr virus (EBV)</li><li><input type="checkbox"/> cold sores</li><li><input type="checkbox"/> genital herpes</li><li><input type="checkbox"/> heart disease</li><li><input type="checkbox"/> rheumatic fever</li><li><input type="checkbox"/> high blood pressure</li><li><input type="checkbox"/> stroke</li><li><input type="checkbox"/> kidney disease</li><li><input type="checkbox"/> urinary bladder problems or infections</li><li><input type="checkbox"/> diabetes mellitus</li><li><input type="checkbox"/> cancer</li><li><input type="checkbox"/> pneumonia</li><li><input type="checkbox"/> emphysema</li><li><input type="checkbox"/> tuberculosis</li><li><input type="checkbox"/> asthma</li><li><input type="checkbox"/> peptic ulcer</li><li><input type="checkbox"/> anemia or other blood disorder</li><li><input type="checkbox"/> bleeding disorder</li><li><input type="checkbox"/> fibromyalgia</li><li><input type="checkbox"/> osteoarthritis</li><li><input type="checkbox"/> rheumatoid arthritis</li><li><input type="checkbox"/> mental disorder</li><li><input type="checkbox"/> gout</li><li><input type="checkbox"/> hepatitis</li><li><input type="checkbox"/> liver cirrhosis</li><li><input type="checkbox"/> gall stones</li><li><input type="checkbox"/> jaundice</li><li><input type="checkbox"/> hernia</li></ul>	<ul style="list-style-type: none"><li><input type="checkbox"/> thyroid disorder</li><li><input type="checkbox"/> disorder of genitals</li><li><input type="checkbox"/> gynecological disorder</li><li><input type="checkbox"/> congenital abnormalities</li><li><input type="checkbox"/> skin diseases</li><li><input type="checkbox"/> elevated cholesterol</li><li><input type="checkbox"/> cardiac pacemaker</li><li><input type="checkbox"/> surgical implants</li><li><input type="checkbox"/> change in bowel or bladder habits</li><li><input type="checkbox"/> sores that will not heal</li><li><input type="checkbox"/> unusual bleeding or discharge</li><li><input type="checkbox"/> indigestion</li><li><input type="checkbox"/> sjögren's disease</li><li><input type="checkbox"/> crohn's disease</li><li><input type="checkbox"/> irritable bowel disease</li><li><input type="checkbox"/> lupus erythmatosis</li><li><input type="checkbox"/> difficulty swallowing</li><li><input type="checkbox"/> obvious change in a wart or mole</li><li><input type="checkbox"/> alzheimer's</li><li><input type="checkbox"/> parkinson's</li><li><input type="checkbox"/> epilepsy or convulsions</li><li><input type="checkbox"/> history of smoking #_____ day</li><li><input type="checkbox"/> history of smokeless tobacco use</li><li><input type="checkbox"/> history of drinking alcohol</li><li><input type="checkbox"/> history of recreational drug use</li><li><input type="checkbox"/> history of sexually transmitted disease</li><li><input type="checkbox"/> HIV</li></ul>
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**PATIENT CONFIDENTIAL INFORMATION**

Patient name \_\_\_\_\_

*Please complete the following as you feel are significant to you.*

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> muscle pain                         | <input type="checkbox"/> shoulder pain  | <input type="checkbox"/> elbow pain                       |
| <input type="checkbox"/> knee pain                           | <input type="checkbox"/> low back pain  | <input type="checkbox"/> neck pain                        |
| <input type="checkbox"/> other joint or muscular pain: _____ |   |   |
| <input type="checkbox"/> migraine headache                   | <input type="checkbox"/> tension headache   | <input type="checkbox"/> cluster headache                 |
| <hr/>  |   |   |
| <input type="checkbox"/> cold/flu/bronchitis/pneumonia       | <input type="checkbox"/> hay fever/allergies  | <input type="checkbox"/> asthma                           |
| <input type="checkbox"/> nose bleeds frequently              | <input type="checkbox"/> wheezing   | <input type="checkbox"/> bad breath                       |
| <input type="checkbox"/> tongue sores                        | <input type="checkbox"/> lack of thirst/forget to drink   | <input type="checkbox"/> easy thirst/dry mouth/dry throat |
| <hr/>  |   |   |
| <input type="checkbox"/> poor or no appetite                 | <input type="checkbox"/> high hunger  | <input type="checkbox"/> nausea                           |
| <input type="checkbox"/> bloating/indigestion/acid reflux    |   | <input type="checkbox"/> abdominal pain/cramp/ulcer       |
| <input type="checkbox"/> hemorrhoids                         | <input type="checkbox"/> hard dry stools  | <input type="checkbox"/> chronic loose stools/diarrhea    |
| <input type="checkbox"/> bowel movement every ____ days      |   |   |
| <hr/>  |   |   |
| <input type="checkbox"/> vertigo, dizziness                  | <input type="checkbox"/> ringing in ears  | <input type="checkbox"/> palpitations/irregular heartbeat |
| <input type="checkbox"/> color blind                         | <input type="checkbox"/> dry eyes   | <input type="checkbox"/> hair loss                        |
| <input type="checkbox"/> eczema/acne/skin eruptions          | <input type="checkbox"/> skin tags on neck  | <input type="checkbox"/> fatty nodules under skin         |
| <input type="checkbox"/> brittle nails                       | <input type="checkbox"/> edema/ water retention   |   |
| <input type="checkbox"/> difficult gaining weight            | <input type="checkbox"/> difficult losing weight  |   |
| <hr/>  |   |   |
| <input type="checkbox"/> I get chills easily                 | <input type="checkbox"/> cold hands and feet  | <input type="checkbox"/> wear socks to sleep often        |
| <input type="checkbox"/> cannot take cold shower             | <input type="checkbox"/> my body is constantly hot  |   |
| ·My body accepts more:                                       | <input type="checkbox"/> the Winter season  | <input type="checkbox"/> the Summer season                |
| <hr/>  |   |   |
| <input type="checkbox"/> insomnia                            | <input type="checkbox"/> sleeping too much  | <input type="checkbox"/> night sweats                     |
| <input type="checkbox"/> anxiety/depression/worry            | <input type="checkbox"/> ADD/ADHD (attention deficit disorder/attention deficit hyperactive disorder) |   |
| <hr/>  |   |   |
| <input type="checkbox"/> incontinence of urine               | <input type="checkbox"/> frequent urination   | <input type="checkbox"/> cloudy / bubbling urine          |
| <input type="checkbox"/> painful burning urination           | <input type="checkbox"/> bladder-kidney stones  | <input type="checkbox"/> urinate _____ x night            |

*Please complete the following as you feel are significant to you.*

- 
- How often do you urinate during the day?  
 every hour  every 2 hours  every 3 hours  every 4 hours
  
  - When passing the bowel, does it most of the time feel complete  or often feel unrelieved?
  
  - When passing the bowel, do you sit for a pro-longed period  or is it excreted in a few seconds?
  
  - How many hours do you need to sleep through the night? \_\_\_\_\_ hours
  
  - Do you enjoy meats or do you find them to be heavy and hardly digestible?
  
  - Do you enjoy fried foods or do you find them to be heavy and hardly digestible?

**PATIENT CONFIDENTIAL INFORMATION**

Patient name \_\_\_\_\_

- Have you been on the Atkins Diet and did well  or got sick from it?
- Do you get seasick or motion sickness easily? yes no
- Do you see yourself accomplishing tasks at the last moment  or by step-by-step increments?
- Are you highly sensitive to initially perceived criticisms  or do you let them pass easily?
- When I act or move, I sweat a lot little almost never.
- I usually sweat on my: head face neck back upper body  
arm pit lower body whole body palm and sole
- You have special fear of or discomfort with height closed places open places insects/reptiles
- Childhood/infantile illnesses wetting bed other \_\_\_\_\_

Check any of the following that gives you negative reaction:

- caffeine milk/dairy wheat/gluten shellfish dander/dust/pollen egg
- melon mango perfumes penicillin nickel in jewelry
- other \_\_\_\_\_

Are you taking herbs? \_\_\_\_\_

**MEN**

- potency issue prostatitis fertility difficulties

**WOMEN**

Age when periods began \_\_\_\_\_ Last pap smear date \_\_\_\_\_

Duration of flow /days \_\_\_\_\_ Is your cycle regular? yes no

Date of the last period \_\_\_\_\_ Do you believe you are pregnant? yes no

Difficulties during period: excessive flow less flow cramps clots breast distension  
emotional changes

fertility difficulties habitual miscarriage breast cysts low libido menopausal symptoms  
vaginal yeast (candida) infections

Menstrual cramps: every or almost every period infrequent

Birth control history, method, & duration of use \_\_\_\_\_

\_\_\_\_pregnancies \_\_\_\_births \_\_\_\_abortions \_\_\_\_miscarriages \_\_\_\_c-sections

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**Patient name** \_\_\_\_\_

What is your major history of illnesses?

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Surgeries & dates \_\_\_\_\_  
\_\_\_\_\_

What is your health goal through the treatment at this clinic?

- pain management    treatment of the illness    preventative lifestyle

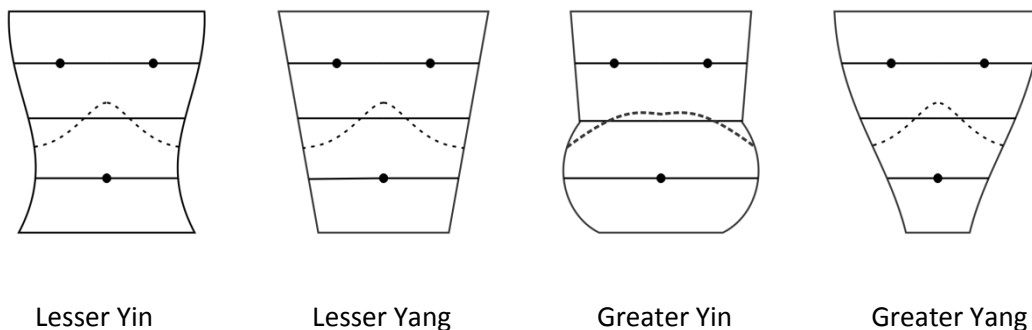
From the above, which conditions bother you the most?

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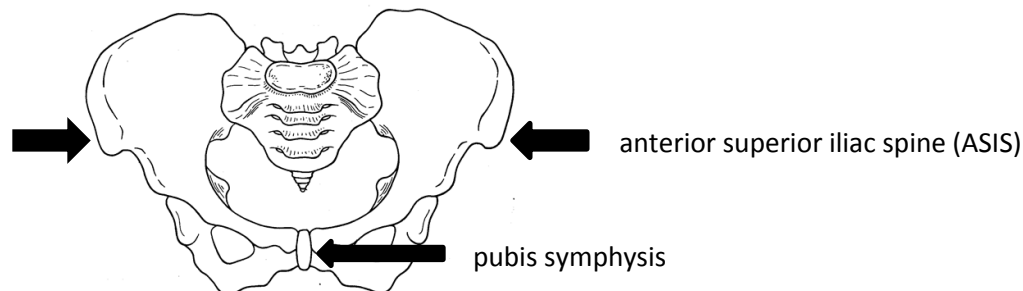
# Patient Torso Measurement Agreement

Dr. David Lee's acupuncture style is based on Four Constitutional Medicine, where knowing your torso shape facilitates identifying your body type and therefore leads to proper treatment for your ailments. He determines your body type diagnosis by measuring five lines as illustrated below with a caliper (a measuring ruler). For females, the second line across the chest is not measured for protection of privacy.

Exaggerated example of torso shapes:



Three points of palpation:



The sides and front of the pelvic bone is also palpated. Below the pubis symphysis is not palpated.

I approve of Dr. David Lee measuring my torso and palpating my pelvic bone for the purpose of establishing an Asian medical diagnosis for the treatment of my illnesses.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

# FINANCIAL POLICY & PATIENT RESPONSIBILITY

We request payment at the time service is provided. We are able to accept the payment in forms of cash, check, American Express, Visa, and MasterCard.

## Charge Rates

Acupuncture for each visit is \$60. Initial consultation fee is \$30.

Herbs are \$60 per bottle for one week supply.

Acupuncture and herbs package fee is \$90.

Dietary consultation fee is \$30.

You will be given options to best treat your complaints.

## Philosophy

We make the highest effort to serve the patients as quickly and economically as possible. Usual visits are twice a week for the first few weeks and once a week thereafter. Refer to the brochures that pertain to you and ask Dr. David Lee about how long and how often your treatments should be to achieve maximum recovery.

## Insurance

If you are requesting to pay for your care through your insurance company, then make sure you are clear with your insurance carrier about your responsibilities, such as deductible and co-pay. Due to the varying calculations involved, please *do not assume the final payment* until you receive the explanation of benefit from your insurance carrier. Please note that you, the patient, have the final financial responsibility for your care. If your acupuncture insurance benefits seem to be vague, then you may be requested to make full payment until the *explanation of benefits* is received. Chinese herbs and dietary consultations are not covered by any insurance plan. I hereby authorize David Lee Acupuncture to release all information necessary to process any insurance or collection claims.

## Cancellation Policy

David Lee Acupuncture's cancellation policy requires patients to give a 24-hour notice of cancellation prior to their appointment. If you are not sure you will make your scheduled appointment, please do not schedule it. As time and space is limited someone else may be able to take your spot if a 24-hour notice is given. We ask that you please value our time and understand the reason for our cancellation policy.

**The cancellation fee for missed appointments or appointments cancelled without a 24-hour notice is \$40.** Patients will not be able to see the doctor for another appointment until the cancellation fee is paid. Exceptions may be made for emergencies on a case-by-case basis.

By signing below you are acknowledging our cancellation policy and agreeing to pay \$40 for missed appointments or appointments cancelled without a 24-hour notice. Thank you for your cooperation.

I understand and agree to the fees outlined above and may receive a copy of this Financial Policy & Patient Responsibility form upon request.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian if patient is a minor