**Radiant Sun Acupuncture Inc.**
**3665 Eureka Way**
**Redding, CA 96001**
**(530) 510-2725**

## Patient Information Form

Please note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Name ______________ M.I. ______________ Last ______________

Address ______________ City ______________ State ______________ Zip ______________

Home Phone ______________ Cell ______________ Work ______________

Age ______________ Date of Birth ______________ Male ☐ Female ☐

Email Address ______________

Employer ______________ Occupation ______________

Married ☐ Single ☐ Divorced ☐ Name of Spouse ______________

Emergency Contact ______________ Telephone ______________

Referred by ______________

### Financial and Insurance Information

Health Insurance Company: ______________

Insurance Address: ______________ City: ______________

State: ________ Zip: ________ Phone: ______________ Adjuster Name: ______________

Policy or ID #: ______________ Group, Plan or Program: ______________ Claim #: ______________

Insured Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Partner Insured: ☐ M ☐ F

Insured Name: ______________ Insured Birthdate: ______________

Insured Address: ______________ City: ______________ State: ______________

Zip: ______________ Insured Phone #: ______________ Emergency #: ______________

Insured Employer & Address: ______________

## RECORDS RELEASE & ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to claims for benefits submitted. I further agree and authorize Erica Shepard, L.Ac
to submit claims for benefits, for services rendered, without obtaining my signature on each claim. I (________________________________________ ) hereby
authorize (_____________________________________________) to pay and hereby assign directly to Erica Shepard, L.Ac. all owed benefits.
I understand that I am financially responsible for all charges incurred, whether or not they are covered by my insurance company. This authorization shall remain valid until written notice is given by me revoking said authorization.

**Signature of Patient**____________________________________________**Date**____________

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## CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment.

**I understand that this information serves as:**

- A basis for planning my care and treatment
- A means of communication among the many professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals

**I understand that I have the right:**

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations-and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

**I request the following restrictions to the use of disclosure of my health information:**

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_______________________________________________    ____________________

**Patient Signature**    **Date**
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# Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or 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 working or associated with, or serving as a back-up for the acupuncturist named below, including those working at this or any other office, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, exercise therapy Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. 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, mineral, and animal 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 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, and 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.

| | |
|---|---|
| ______________________________ | ______________________________ |
| Print Name of Patient | Print Name of Acupuncturist |
| X______________________________ | X______________________________ |
| Signature of Patient (or Representative) | Signature of Acupuncturist |

NAME_______________________________ DATE_________________________

**I. Goals:** What would you most like to achieve through your work at Radiant Sun Acupuncture Inc.?

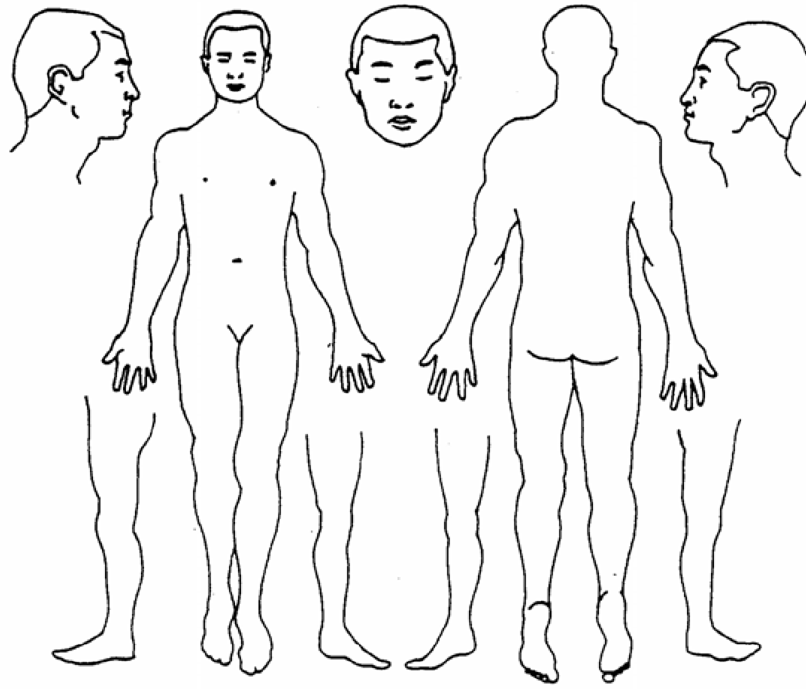
1.___________________________________________________________________________________
2.___________________________________________________________________________________
3.___________________________________________________________________________________
4.___________________________________________________________________________________
5.___________________________________________________________________________________

**II. Major Symptoms:** Please list in order of importance what symptoms are of concern to you.
*(Most concerning to least, along with the duration of the symptom)*

1.___________________________________________________________________________________
2.___________________________________________________________________________________
3.___________________________________________________________________________________
4.___________________________________________________________________________________

**Use the following illustration to indicate painful or distressed areas:**

Are you experiencing pain/discomfort in any area of your body? **Y/N**
If yes using the model below, please indicate the location of the discomfort.



| Area Description of Symptoms | Pain Level 0-10 | Frequency |
|---|---|---|
| _________________________________ | _____________ | _____________ |
| _________________________________ | _____________ | _____________ |

**For Women:**

1. Are you pregnant now?  Yes [   ] No  [   ] Unsure [  ]

2. Indicate number of occurrences:
Live Births ________ Pregnancies________ Miscarriages ________ Abortions ________

3. Age: First period ______ Menopause (if applicable) ______

4. Date: Last Pap Smear ______ /______ Last Mammogram ______ / _______

5. Any History of an Abnormal Pap Smear? [   ] Yes [   ] No If so, what /when______________________________

6. Are your menses cycle regular? [   ] Yes [   ] No
a) Average number of days of flow _______
b) The flow is:  Normal [   ] Heavy [   ] Light [  ]
c) The color is:  Normal [   ] Dark [   ] Purple [   ] Light Brown  [ ] Brown [  ]

7. Do you have any of the menstruation related signs or symptoms?

[   ] Difficulty with Orgasm    [   ] Cramps    [   ] PMS    [   ] Bleeding between Periods

[   ] Vaginal discharge    [   ] Nausea    [   ] Blood Clots    [   ] Breast Distension

[   ] Heavy Vaginal Discharge Between Periods

**For Men:**

1. Do you have any bothersome urinary symptoms?   Yes [   ] No [  ]

Describe:
_____________________________________________________________________________________

2. Check all that apply:

[  ] Erectile Dysfunction    [  ] Difficulty with Orgasm    [  ] Pain or swelling of the testicles

[  ] Impotence    [  ] Premature Ejaculation    [  ] Frequent need to urinate at night

[  ] Feeling of coldness or numbness of the genitalia

3. Do you get up at night to urinate?  Yes [   ] No [  ]    How often? __________________________________

## III. Medical History

| *Please check all that apply* | *Date Diagnosed* | | *Date Diagnosed* |
|---|---|---|---|
| Diabetes | ___/___/___ | High Cholesterol | ___/___/___ |
| High Blood Pressure | ___/___/___ | Seizures | ___/___/___ |
| Thyroid Disease | ___/___/___ | Hepatitis | ___/___/___ |
| Cancer | ___/___/___ | | |
| HIV | ___/___/___ | | |

## IV. Surgical History

_______________________________________________ Date__________
_______________________________________________ Date__________
_______________________________________________ Date__________
_______________________________________________ Date__________

## V. Family History

Please check all that apply and state how you are related to the family member with that condition.

| Condition | Mother | Father | Sibling | Maternal Grandparent | Paternal Grandparent |
|---|---|---|---|---|---|
| Heart Disease | | | | | |
| Cancer | | | | | |
| Hypertension | | | | | |
| Stroke | | | | | |
| Substance Abuse | | | | | |
| Asthma | | | | | |
| Allergies | | | | | |
| Migraines | | | | | |
| Depression | | | | | |
| Other Mental Illness | | | | | |
| Glaucoma | | | | | |
| Osteoporosis | | | | | |
| Diabetes | | | | | |
| Other | | | | | |

## VI. Medications/Supplements

Medications you are currently taking (please include prescription medicine, supplements and over the counter medicines you take on a regular basis, along with dosages and brands if know).

_________________ _________________ _________________
_________________ _________________ _________________
_________________ _________________ _________________
_________________ _________________ _________________

Allergies (to medications, chemicals or foods)

_________________ _________________ _________________
_________________ _________________ _________________

## VIII. Nutrition

1. Do you follow a special diet? Yes [ ] No [ ]
If yes, how would you describe your diet?

_______________________________________________
_______________________________________________
_______________________________________________

## IX. Social History

1. How much per day do you use of the following?
a) Coffee, tea, soft drinks:

______________________________________________________________________________

b) Alcohol:

______________________________________________________________________________

c) Cigarettes, cigars, other tobacco:

______________________________________________________________________________

d) Other drugs:

______________________________________________________________________________

2. In the past year, how many days have you been significantly affected by your health? ________________

3. How many days did you feel generally poor? _________

4. How many times were you in the hospital? __________

5. Please describe your current exercise regimen:

Hours per week: _______ Activities: ____________________________________________ [ ] No Exercise

6. How many hours of sleep do you usually get per night during the week? _______________

7. Do you awake feeling rested? [ ] Yes [ ] No

Do you feel you sleep well at night? [ ] Yes [ ] No

Please provide us with any other information that you think is relevant for us to know:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________