Lynn Cheng Holistic Healing

Confidential Patient Information Form

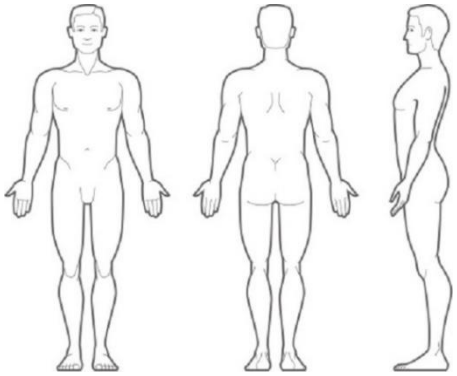
Name:_____Date:_____
Address:_____Zip:____
Phone:_____Cell:_____
Email:_____ Height: _____ Weight: _____
May I contact you via mail or email with newsletters/special offers? _ Yes _ No
How did you hear about me?

- ___Referred by friend or family member: Name: _____
- ___I'm a MindBodyZone member
- ___I attend your yoga classes
- ___Yelp
- ___Online search
- ___Facebook
- ___Instagram
- ___Other: _____

Sex: __ M __ F __Other Birthdate: _____/_____/_____
__Single __Married/Partnership __Divorced __Widowed __Separated
Occupation:_____Employer:_____
Emergency Contact:_____Phone:_____
Is this your first time receiving acupuncture? __Yes __No
Are you pregnant/is there a chance that you are pregnant? __Yes __No
Are you taking Coumadin or Warfarin? __ Yes __No
Do you bruise easily or bleed for a long time? __ Yes __No
Do you tend to faint? __ Yes __No
Allergies (food, drugs, seasonal, etc):_____

Please indicate areas of pain (if any):
Is the pain/discomfort:
___ sharp __ dull __burning ___achy
__ stiff ___other: _____

Rank the pain on a scale of 1-10 _____
(1-mild, 5-moderate, 10-severe)



LIFESTYLE/HABITS

Exercise: (check one)
__Mostly sedentary (little to no activity in career/home)
__Mild exercise (housework, climb stairs, gardening, etc.)
__Occasional vigorous exercise (moderate manual labor, exercise <4x/week for 30 min)
__Regular vigorous exercise (hard manual labor, exercise >4x/week for 30 min)
__Extreme exercise (professional athlete, serious athlete, exercise 6-7x/week for >45 min)
Type of exercise/activity: _____

Typical Diet:

Morning _____

Lunch_____

Dinner_____

Snacks_____

Please list any dietary restrictions_____

How much of the following do you drink per day? Water (oz.)_____Soft Drinks (cans)_____

Place an **X** where you fall on these continuums:

Temperature (wearing more/less layers): COLD|----------|----------|HOT

Moisture (skin/mouth/hair/bowels etc): DRY|----------|----------|OILY

Digestion: DIARRHEA|----------|----------|CONSTIPATION

Energy: LOW|----------|----------|HIGH

HEALTH HISTORY

Medications, supplements, **herbs** you take regularly (prescribed or otherwise):

Name	Purpose	Date/year started taking
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____

Health Conditions:

Circle 🧍 if YOU have/had the condition and note the year it started.

Circle 👨‍👩‍👧 if there is a family history of the condition

	You	Year	Family		You	Year	Family
Cancer: type? _____	🧍	_____	👨‍👩‍👧	Pacemaker	🧍	_____	👨‍👩‍👧
Diabetes	🧍	_____	👨‍👩‍👧	Osteoporosis	🧍	_____	👨‍👩‍👧
Hepatitis: type? __	🧍	_____	👨‍👩‍👧	Kidney disease	🧍	_____	👨‍👩‍👧
High Blood Pressure	🧍	_____	👨‍👩‍👧	Autoimmune disease	🧍	_____	👨‍👩‍👧
Heart disease	🧍	_____	👨‍👩‍👧	Anemia	🧍	_____	👨‍👩‍👧
Stroke	🧍	_____	👨‍👩‍👧	HIV/AIDS	🧍	_____	👨‍👩‍👧
Seizure disorder	🧍	_____	👨‍👩‍👧	Alcoholism	🧍	_____	👨‍👩‍👧
Thyroid disorder	🧍	_____	👨‍👩‍👧	Drug Addiction	🧍	_____	👨‍👩‍👧
Asthma	🧍	_____	👨‍👩‍👧	Arthritis	🧍	_____	👨‍👩‍👧
High cholesterol	🧍	_____	👨‍👩‍👧	Suicide	🧍	_____	👨‍👩‍👧
Vegetarian/Vegan	🧍	_____	👨‍👩‍👧	Mental Illness	🧍	_____	👨‍👩‍👧

SYMPTOM SURVEY

The following is a list of symptoms that you may or may not experience. Please indicate as follows: leave **blank** if never experience, **check (√)** if sometimes experienced in the past 6 months, **plus sign (+)** if frequently experienced in the past 6 months.

EARTH

__decreased appetite
__increased appetite
__lack of taste
__loose stools or diarrhea
__constipation
__hemorrhoids
__vomiting/nausea
__abdominal pain
__digestive problems
__indigestion
__belching, burping
__recent use of antibiotics
__heartburn/reflux
__bad breath
__feeling of food "sitting" in the stomach
__heavy sensation in body
__edema/swollen
__sleepy after eating
__muscles feel tired often
__easily bruised
__difficult to stop bleeding
__crave sweets
__tendency to gain weight
__hard to get up in the am
__tendency to become obsessive or compulsive
__overthinking
__worry

METAL

__cough
__phlegm
__shortness of breath
__decreased sense of smell
__nasal problems
__nasal congestion
__sinus infection/congestion
__asthma
__allergies/hay fever
__skin rashes/dermatitis
__eczema/psoriasis
__itchy/red/painful throat
__dry mouth/throat/nose
__bronchitis/pneumonia
__tendency to catch colds easily
__intolerance to weather changes
__snoring
__easy or excessive sweat
__feeling grief or sadness

FIRE

__colitis or diverticulitis
__high blood pressure
__low blood pressure
__mouth ulcers
__insomnia, difficulty sleeping
__nightmares
__vivid dreams
__tight chest feeling
__heart palpitations
__chest/angina pains
__manic episodes
__mentally restless
__difficulty concentrating
__frequent crying
__easily startled
__lack of joy in life
__laughing for no apparent reason
__anxiety

WOOD

__dry hair
__dry/red/itchy eyes
__blurry vision
__eye floaters/spots
__poor night vision
__difficulty digesting oily or greasy foods
__gall stones
__soft or brittle nails
__spasms or twitching of muscles/tremors/cramping
__tendonitis
__numbness/pins & needles
__headaches
__migraines
__dizziness
__vertigo
__breast lumps
__PMS
__feeling of lump in throat
__clenching of teeth at night
__neck/shoulder tension
__emotional eater
__easily angered or agitated
__difficulty in making plans
__indecisive
__lack of motivation
__irritable/anger/frustration
__depression
__stressed
__bitter taste in mouth
__timid/shy
__frightens easily

WATER

__low back pain/sore/weak
__knee pain/sore/weak
__hearing impairment
__ear ringing/tinnitus
__cold hands/feet
__kidney stones
__decreased sex drive
__increased sex drive
__hair loss
__urinary problems/incontinence
__bladder infections
__cavities
__decreased bone density
__hot flashes
__night sweats
__impotence
__premature ejaculation
__poor memory
__fear

Lynn Cheng Holistic Healing

Informed Consent to Treatment

I hereby request and consent to the performance of acupuncture and other procedures by the licensed acupuncturist Lynn Cheng and/or other licensed acupuncturists who now or in the future treat me while working with Ms. Cheng or serves as a back-up for her in the event of a necessary cancellation, including those working in the same office, whether signatories to this form or not. I have discussed the nature and purpose of my treatment with Lynn Cheng.

I understand that methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, gua sha, electrical stimulation, and bodywork therapies such as Trigger Point Massage, Medical Massage, Tui Na (Chinese Massage) and yoga. It may also involve the modalities of herbal medicine, nutritional advice, and lifestyle counseling consistent with the principles of holistic Chinese medicine. I understand that Lynn Cheng performs acupuncture treatments with the insertion of acupuncture needles through the skin, or by the application of heat to the skin, or by both in an attempt to support the body's physiological functions.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, bleeding, temporary pain and discomfort, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting and temporary aggravation of symptoms in existence prior to treatment. Bruising is a common side effect of cupping. Burns and/or scarring are a potential risk of moxibustion. Pain and soreness are a possible result of body work. Rare and unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this site uses sterile, single use, disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I also understand that Chinese medicine is not primary care medicine and that if my symptoms worsen, new symptoms arise, or I have any concerning change in my health status I should consult a licensed medical doctor. I do not expect Lynn Cheng to be able to anticipate and explain all possible risks and complications of treatment. I understand that I should inform her prior to being treated if I believe I might be pregnant. I understand that no results are guaranteed concerning acupuncture's and associated techniques, and that I am free to stop acupuncture treatment at any time. None of the foregoing provisions preclude the administration to me of conventional medical therapy by a licensed physician when such therapy is deemed appropriate. I understand that Lynn Cheng may discuss my case to provide thorough and accurate treatment of my condition. Otherwise all my records will be kept confidential and will not be released to any party without my written consent.

I agree to abide with the Covid-19 office policies and understand that while extraordinary steps are being taken to ensure the safety and good health of both patients and practitioners, 100% protection from infection cannot be 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.

To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated).

Date Consent Completed _____

_____ _____

Print Name of Patient | Print Name of Patient Representative (if applicable)

_____ _____

Signature of Patient or Representative | Name & Signature of Acupuncturist: Lynn Cheng

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Office Policies

POLICY IN THE WAITING AND TREATMENT ROOMS: All types of electrical equipment (i.e. cell phones) must be turned off during the treatment and while in the waiting room. Please keep voices to a minimum as others may be receiving treatments at this time.

PAYMENT: Payment is due at the time of service. Cash, checks, Zelle, and Health Savings/FSA cards are all acceptable forms of payment. Please be advised that any returned checks will be charged a $30 handling fee.

CANCELLATIONS, MISSED APPOINTMENTS, AND LATE POLICY: Your appointment time is reserved specifically for you. Please give a minimum of 24 hours' notice when canceling your appointment. Patients who do not show up for their appointment or cancel less than 24 hours prior to their treatment will be charged $95. Insurance will not pay for a missed appointment. A patient more than 10 minutes late may not be seen or may have an abbreviated treatment and the treatment will still end at the regularly scheduled time. For example, if a patient had an appointment from 5-6pm and arrives at 5:15, the treatment will still end at 6pm and the patient will be expected to pay the full cost of the treatment.

REASONS FOR BEING DISMISSED/DENIED TREATMENT: Patients who show inappropriate conduct, non-or late payment of fees, have signs/symptoms of Covid-19, or safety concerns may be denied treatment.

COVID-19: You will NOT be seen in person if you are sick and have ANY of these symptoms: fever, body aches, sore throat, cough, shortness of breath, fatigue, loss of taste/smell, stuffy nose, sinus issues, new or sudden digestive upset. Instead, we can do an online telemedicine appointment. Also, if you have come in direct contact with a Covid positive person, you must wait 14 days and be asymptomatic and/or receive a negative Covid-19 test result in order to schedule an in-person appointment. If you make an in-person appointment and develop any of the above symptoms, you will need to cancel the appointment. I am waiving cancellation fees for this reason only. A mask must be worn for the entire duration of your appointment. Upon arrival, you will wash your hands and wrists. During our intake/consult, we will maintain 6 feet apart.

INSURANCE: This office does not file insurance forms. I will gladly give you a receipt for all your treatments so you can submit them to your insurance company for request of reimbursement. Please verify with your insurance company that you will be reimbursed.

PLEASE INDICATE YOUR UNDERSTANDING AND ACCEPTANCE OF THESE POLICIES BY SIGNING BELOW.

Signature of patient/guardian:_____ Date:_____

Printed name of patient:_____

Lynn Cheng Holistic Healing

Privacy Policies

Dear Valued Patient,

This notice describes my office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected. To maintain the level of service that you expect from my office, I may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at my office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use: In administering your health care, I gather and maintain information that may include non-public personal information:

- About your financial transactions with me (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (e.g. requests for medical records, claim payment information).

Marketing: This office will not use your health information for marketing communications without your written authorization. However, this office may send birthday cards, newsletters and appointment reminders, by telephone calls, or mail.

Disclosure: This office may use or disclose your Protected Health Information when required by law.

Patient Rights

1. Upon written request, you have the right to access, review or receive copies of your healthcare records. There is a copy fee of $20 and 10 working days to process it.
2. Upon written request, you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing. If you have questions, complaints or want more information, please contact this office. I have read, reviewed, understand and agree to the statement of the Privacy Policy for healthcare services in this office.

Patient Signature_____

Date_____

If I would like to review the Privacy Policies, I may request a copy from Lynn Cheng Holistic Healing LLC.