NEW PATIENT REGISTRATION & HISTORY

How did you hear about us: ☐ Website ☐ Referral, if so, whom may we thank: ☐ Other:

Patient Information

Last Name:	First Name:	Sex: ☐ M ☐ F	DOB:
Street Address:			
City:	State:	Zip:	
Home Phone:	Cell Phone:		
Email:			

Employment Information

Occupation:	Employer:
Employer Address:	
Employer Phone:	

Emergency Contact Information

Contact Name:	Relationship to Patient:
Phone:	

Insurance Information

Subscriber Name:	Subscriber DOB:	
Relationship to Patient:	Insurance Co:	
ID #:	Group #:	Is patient covered by additional insurance? ☐ Yes ☐ No

Exercise	Work Activity	Habits
☐ None	☐ Sitting	☐ Smoking, Packs/Day________________________
☐ Moderate	☐ Standing	☐ Alcohol, Drinks/Day or Week_________________
☐ Heavy	☐ Light Labor	☐ Coffee/Caffeine Drinks, Cups/Day_____________
	☐ Heavy Labor	☐ High Stress Level, Reason_____________________

Medications & Purpose (list)	Allergies	Supplements

Health History (check all that apply)

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies (shots?)
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken pox
- ☐ Chronic fatigue
- ☐ COPD/Emphysema
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease
- ☐ Herpes
- ☐ High blood pressure
- ☐ High blood cholesterol
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated disc
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problems
- ☐ Prosthesis
- ☐ Psychiatric care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Skin Conditions
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Urinary Tract Infections
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Other

Females Only: Are you pregnant? ☐ Yes ☐ No Due Date:

Do you have any skin conditions today? ☐ Skin Rash ☐ Cuts/Scrapes/Bruises ☐ Burns

List injuries/surgeries including dates and description:

Family History (check all that apply to immediate family members)

- ☐ Asthma
- ☐ Arthritis-Rheumatism
- ☐ Back Problems
- ☐ Cancer
- ☐ Circulation Problems
- ☐ Diabetes
- ☐ Emphysema
- ☐ Headaches
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Ulcer/Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease

Primary Care Physician (PCP):____

Address:____

Phone:__________________________________ Date Last Seen:______________________________

I give Kirkland Whole Life Clinic permission to contact my PCP for medical history/treatment plan: ☐ Yes ☐ No

Patient Condition

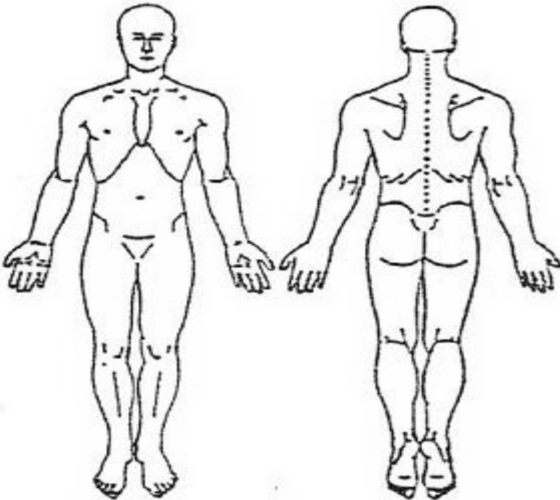
Reason for Visit and Goals:

What treatment, if any, have you received for this condition? ☐ Medical ☐ Physical Therapy ☐ Massage ☐ None
☐ Other (please describe):

Name/address of other doctor(s) who have treated you for this condition:

Is condition due to an accident? ☐ Yes ☐ No If yes, date:	Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other
Have you reported the accident? ☐ Yes ☐ No	If yes, to whom? ☐ Auto Insurance ☐ Employer ☐ Worker Comp ☐ Other

Attorney Name & Phone # (if applicable)



How often are symptoms occurring?

☐ daily x ___ ☐ weekly x___ ☐ monthly x___ ☐ constantly

How long does each episode last?

☐ only as long as the activity lasts ☐ seconds ☐ minutes ☐ hours
☐ days ☐ constant

Rate severity of symptoms on graph below:

No Pain -- Severe Pain

List any activities that are inhibited by your symptoms:

Describe pain/symptoms as they are today: ☐ aching ☐ burning ☐ stabbing ☐ shooting ☐ sharp ☐ dull ☐ electric
☐ tingling/prickly ☐ numbness ☐ other:_____________________

Are there any questions, or other symptoms/concerns you want the practitioner to know about:

Assignment and Release: I, the undersigned, certify that I (or my dependent) have insurance coverage with above stated company/companies and assign directly to Kirkland Whole Life Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_______________________________ _______________________

Signature of Patient or Patient's Representative Date

Representative's relationship to patient: _______________________________

INFORMED CONSENT FOR ACUPUNCTURE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture (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 the acupuncturist named below, including those working at the clinic or office listed below.

I understand that methods of treatment may include, but are not limited to, acupuncture, cupping, gua sha, electrical stimulation, Tui-Na (Asian Bodywork), 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 in writing. Some herbs may have 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 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 clinic uses *sterile disposable needles* and maintains a clean and safe environment. Burns and/or scarring are a potential risk of cupping. I understand that while this document describes the major risks of treatment, other side effect 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 clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical 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.

Female ONLY: Are you pregnant or nursing? □ YES □NO If yes, please check one: □ pregnant □ nursing

Patient's Signature **Patient's Name (PLEASE PRINT)** **Date**

To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or is physically or legally incapacitated

Patient's Name (PRINT) ______________________________ **Representative's Name (PRINT)** ________________________

Relationship/Authority to Patient ____________________ **Witness** ____

Representative's Signature __________________________ **Date Signed** ____

HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent form I authorize the *Kirkland Whole Life Clinic* to use and disclose my protected health information for the following purposes:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company); and
- Day-to-day healthcare operations of the Kirkland Whole Life Clinic such as quality assessments.

I have also been informed of and given the right to review and secure a copy of Kirkland Whole Life Clinic's Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA.

____
Patient Name (please print)

____
Patient/Guardian Signature

____
Date

Patient Notification of Dr. William Duarte's Qualifications & Scope of Practice

Dr. William Duarte is a licensed East Asian Medicine Practitioner (EAMP). This is the formal title for Acupuncture and Oriental Medicine practitioners in the State of Washington. East Asian medicine includes a broad range of medicine practices sharing common concepts which developed in China and are based on a tradition of more than 2,000 years, including various forms of herbal medicine, acupuncture, massage, exercise and dietary therapy. Dr. Duarte's qualifications/certification and scope of practice follows:

1. **Education and License:**

- Oregon College of Oriental Medicine, Portland, Oregon (1993)
- EAMP License #: AC60334194 issued by Washington State Department of Health; Status: Active

2. Scope of Practice:

- Acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate
  acupuncture points and meridians; use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians; moxibustion; acupressure; cupping; dermal friction technique; infra-red heat; sonopuncture; laserpuncture; Point injection therapy (aquapuncture).

- Dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements.

- Breathing, relaxation, and East Asian exercise techniques; Qi gong; East Asian massage and Tui na, which is a method of East Asian bodywork characterized by the kneading, pressing, rolling, shaking, and stretching of the body; and superficial heat and cold therapies.

I, ___________________________________, (patient) have received a copy of this notification.

____

Patient Name (please print)

____   ___________________________________

Patient/Guardian Signature   Date

Cancellation and Missed Appointments Policy

We understand there may be extenuating circumstances; however, we request that any cancellation or rescheduling of your appointment be made at least 24 hours in advance of the scheduled visit. Missed appointments or appointments cancelled less than 24 hours in advance can prevent us from serving others in need and disrupt our practitioner's schedules.

The fee for missed appointments/late cancellation is $50.

Please note that insurance does not pay for cancellation or missed appointment fees.

* * *

I, the undersigned, have been informed about the cancellation and missed appointment policy. I have further been informed that reminder calls are a courtesy and that I am responsible for remembering my appointment.

____
Name (please print)

____ ______________________________
Signature Date

INITIAL INTAKE NOTE

Name:	DOB:	Date:

SUBJECTIVE:

OBJECTIVE:

Restrictions to articular ROM noted in: ☐ Cx ☐ Thx ☐ Lx ☐ SI ☐ Other:

(HT=Hypertonic, TP=Trigger Point, ADH = Adhesions(s), INF = Inflammation, Palpatory Pain Scale of 0-4, tight and tender to blanching pressure)

Sub Occipital mm.___, *Cx Paraspinal* mm.____, L/R/Bi *Scm*____, L/R/Bi *Scalenes*____, L/R/Bi *Levator*____, L/R/Bi Up. Trap.____, L/R/Bi *SupraSpinatous*____, L/R/Bi *Teres/SubScrap* mm.____, L/R/Bi Mid. Trap.____, L/R/BI *Rhomboids*____, *Thx Paraspinal* mm.____, *Lx Paraspinal* mm.____, L/R/Bi *QL*____, L/R/Bi *Gluteal* mm.____, L/R/Bi *Piriformis*____, Other____________________

ASSESSMENT/DIAGNOSIS:

PROCEDURE/TREATMENT PLAN:

☐ Acux 97810
☐ Acux+15m 97811
☐ Elec Acux 97813
☐ Elec Acux+15m 97814
☐ Herbs/Supplements 99070
☐ Physical Therapy 97110: _____minutes
☐ NMR 97112: _____minutes
☐ Therapeutic Activities 97530:_____minutes

☐ Hot/Cold Pack 97010: _______minutes
☐ Infrared 97026: _______minutes________________________________location
☐ Electric Stim 97032: _______minutes______mA______________________location
☐ Myofascial Release 97140: _______minutes
☐ Massage Therapy 97124: _______minutes________________________________location
☐ Full Body ☐ Deep Tissue ☐ Stripping ☐ ROM ☐ ART ☐ Trigger Pt. ☐ Cross Fiber Fr.

LMP: ______________________________ Physician: ____________________________________ Date: _________________

Jessica Cortez, LMP *William Duarte, DAOM, LAc, EAMP*