Shen Ming

Health Cultivation Center

PATIENT INFORMATION

Last Name:_____ First Name:_____ M.I._____

Is a Parent/Guardian completing this form? Yes___ No___
Name and Relationship to Patient: _____

Today's Date:____/____/____ ☐Male ☐Female S.S.# _____
Date of Birth: ____/____/____ Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other _____

Home Address: _____ Apt. _____ Billing Address: _____ Apt. _____
City: _____ State: ____ Zip: _____ City: _____ State: ____ Zip: _____

Home Tel ( ) _____-_____ Cell: ( ) _____-_____ Work: ( ) _____-_____
E-mail: _____
How would you like to be contacted: _____
How did you hear about us?_____

EMERGENCY CONTACT

Name: _____ Relationship to you _____
Address:_____
City: _____ State: _____ Zip: _____
Daytime Phone: ( ) _____-_____ Evening: ( ) _____-_____ Cell ( ) _____-_____

EMPLOYER INFORMATION

Employer: _____ Occupation: _____
Employer Address:_____ Telephone:( )_____-_____

INSURANCE INFORMATION

Primary Insurance Company	Secondary Insurance Company
Policy Holder's Name (if not patient)	Policy Holder's Name (if not patient)
Policy Holders Date of Birth	Policy Holders Date of Birth
Policy #	Policy #
Group #	Group #
Claim's Address	Claim's Address

Insurance Tel #	Insurance Tel #

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CONFIDENTIALITY AGREEMENT

Last Name _____ First Name _____

DOB _____/_____/_____ Today's Date _____/_____/_____

Patient Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received from the office of Shen Ming Health Cultivation Center a copy of the Privacy Practices dated September 2014.

_____ _____

Patient Signature *Date*

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9/15/14, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, please contact us.

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FINANCIAL RESPONSIBILITY POLICY

Patient Acknowledgment of Financial Responsibility Policy

Please read thoroughly and acknowledge that you will adhere to the following Shen Ming Health Cultivation Center payment policies:

1. I understand that the cancellation policy for appointments is 48 hours in advance of my scheduled appointment. If I do not cancel within 24 hours of my appointment, I will be responsible for a $75 cancellation fee. This fee may be waived by Shen Ming Health Cultivation Center due to the specific circumstances.

2. I am responsible for paying fees at the time of service. Accepted forms of payment are personal checks, Visa, MasterCard & American Express. I will be responsible for a $25.00 service charge for non-sufficient funds.

3. If I have provided insurance information, I will pay co-pay or co-insurance at the time of service. I understand that insurance reimbursements are based on my individual health plan, and are subject to deductibles, co-pays, and/or other plan limitations.

4. I acknowledge that Shen Ming Health makes no guarantee on insurance plan reimbursements.

5. If Shen Ming Health submits my insurance, I am responsible for returning any insurance reimbursements within 15 days to Shen Ming Health Cultivation Center that are remitted to me. I have provided credit card information and understand that any unpaid balances or unsurrendered reimbursements will be charged to my card 30 days after service.

6. I acknowledge that herbal consultations, herbal products, and non-acupuncture services are not covered by insurance. I am responsible for the full balance of these products and services at the time of service.

7. If I opt to submit insurance claims on my own behalf, I will be provided a Superbill to submit to my insurance company. I understand that Herbal Products are not included on Superbills and are not returnable.

I have read and agree to the above terms and conditions.

_____ _____

Patient Signature *Date*

Credit Card Information

MasterCard _____ Visa _____ AMEX _____

Card #_____ Expiration Date_____ CVV_____

Name On Card_____

Signature_____

Billing Address:_____

Shen Ming

Health Cultivation Center

MEDICAL HISTORY

NAME: _____ DATE:_____

Goals: What would you most like to achieve through your work at Shen Ming Health Cultivation Center?

1. _____

2. _____

3. _____

4. _____

5._____

Major Concerns: Please list in order of importance what problems or symptoms are of concern to you. (most concerning to least, along with the duration of the symptom)

Problem & Duration	Mild	Moderate	Severe	Previous Treatment & Outcome	Excellent	Fair	No Change
Example: Back Pain 8 months			*X*	*Chiropractor*	*X*		

When was the last time you felt well? _____

Did something trigger a change in health? _____

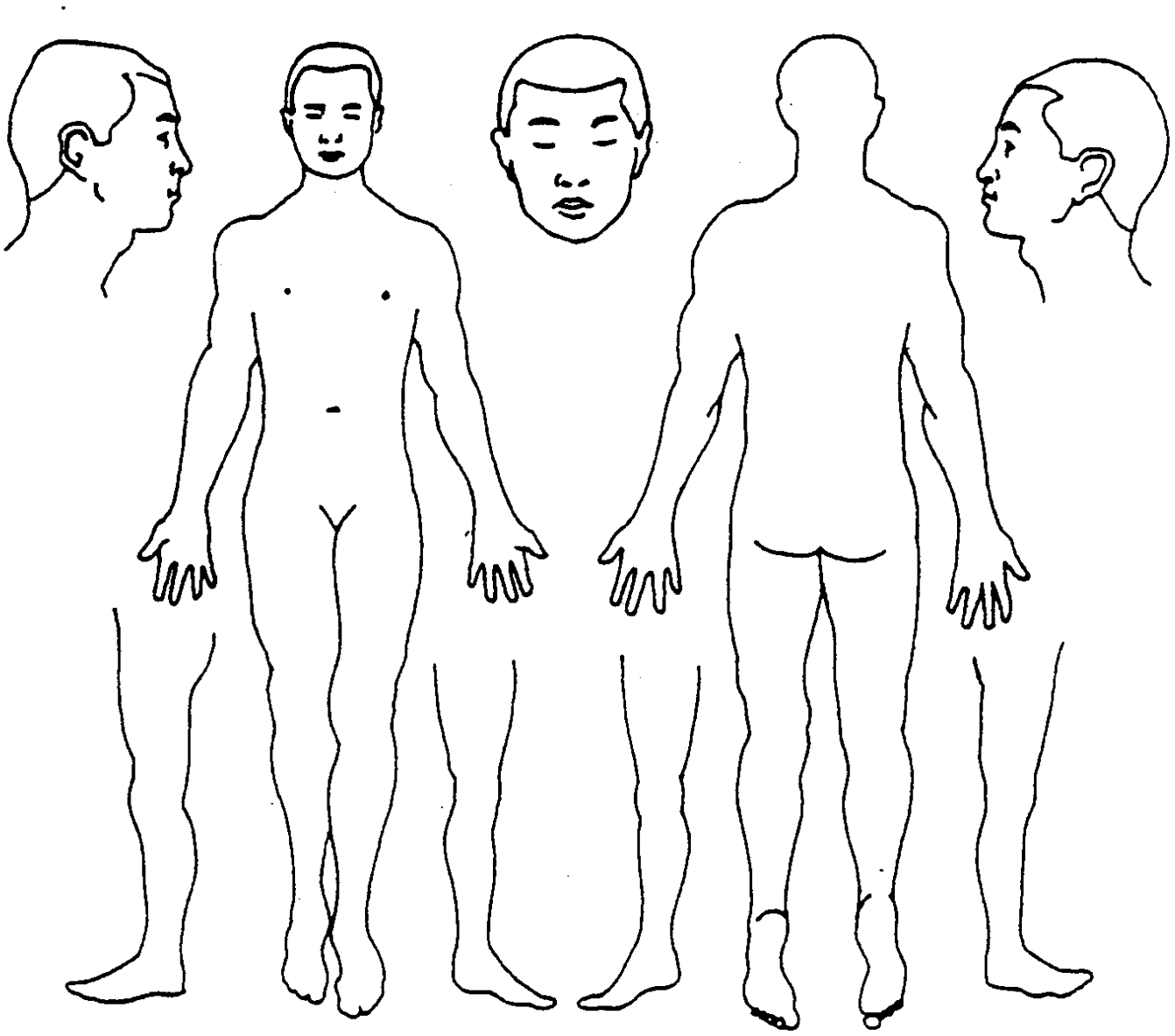
What makes you fell worse? _____

What makes you feel better? _____

Pain Location:

Use the following illustration to indicate painful or distressed areas:

X = MILD XX = MODERATE XXX = STRONG



Symptoms: *Please check all of the following symptoms that you are currently experiencing:*

General:

___Poor Sleeping
___Fatigue
___Fevers
___Chills
___Tremors
___Sweat Easily
___Night sweats
___Poor Appetite
___Cravings
___Weight Gain
___Weight Loss
___Changes in Appetite
___Localized Weakness
___Poor Balance
___Bleed or Bruise easily
___Hot Flashes
___Catch colds easily
___Peculiar tastes/smells
___Strong thirst (hot or cold)
___Fainting
___Allergies
___Sudden energy drop
___General feeling of heaviness
___Mentally sluggish or foggy
___Seizures

Skin and Hair:

___Rashes
___Ulcerations
___Hives
___Itching
___Eczema
___Psoriasis
___Recent Moles
___Skin Discoloration
___Dandruff
___Loss of Hair
___Heat sensations hands/feet/chest
___Change in hair/skin texture
___ Dry Skin
___Dry Hair
___Acne

Head, Eyes, Ears, Nose and Throat:

___Dizziness
___Concussion
___Headaches
___Migraines
___Facial numbness
___Facial Pain
___Declining Vision
___Shortsighted
___Blurry Vision
___Glasses
___Eye Strain
___Eye Pain
___Blood shot/dry eyes
___Discharge from eyes
___Spots in front of eyes
___Floating spots in eyes
___Farsighted
___Night blindness
___Color Blindness
___Cataracts
___Glaucoma
___Macular degeneration
___Poor Hearing
___Ringing in Ears
___Earaches
___Frequent Ear infections
___Sinus Problems
___Nose Bleeds
___Dry mouth, nose, throat
___Recurrent sore throats
___Bleeding swollen gums
___Sores on lips or gums
___Grinding teeth /TMJ
___Teeth sensitivity/decay

Neuropsychological:

___Anxiety
___Panic attacks
___Poor Memory
___Depression
___Inability to concentrate
___Easily angered
___ADD
___ADHD
___OCD
___Insomnia

Musculoskeletal:

___Low Back Pain
___Joint pain, where?
___Muscle spasm/cramping
___Stiff neck/ shoulders
___Neck Pain
___Joint deformity
___Muscle twitching/tremor
___Back Pain
___Knee pain
___Hot or cold joints
___Loss of muscle mass
___Limited range of motion of a joint, where? _____
___Loss of flexibility/tight muscles

Cardiovascular:

___Palpitations
___Swelling of hands
___Blood clots
___High blood pressure
___Dizziness
___Swelling of feet
___Myocardial infarction
___Chest pain
___Fainting
___Chest pain radiating to shoulder
___Tightness in Chest
___Irregular heartbeat
___Cold hands or feel
___Numbness of hands or feet
___Any other heart or blood vessel problems_____

Respiratory:

___Coughing blood
___Asthma
___Sinus congestion
___Cough, periodical
___Coughing sputum
___Pneumonia
___Cough, constant
___Bronchitis
___Pain with deep breath
___Shortness of breath, if so during ___ rest or ___exercise
___Difficulty breathing when lying down

Gastrointestinal:

___Constipation
___Abdominal pain/cramps
___Bad breath
___Nausea
___Chronic laxative use
___Gas
___Bitter taste in mouth
___Vomiting
___Stomach pain
___Belching
___Rectal Pain
___Loose Stools
___Heartburn
___Bloating /gas after eating
___Hemorrhoids
___Diarrhea
___ Indigestion
___Feeling tired after eating
___Bloody stools
___Diarrhea alternating with constipation
___Prolapsed Organs
___Black stools

Urinary : Urination is:

___Normal color
___Cloudy
___Painful
___Frequent
___Clear/Pale
___Scanty
___Bloody
___Infrequent
___Dark Yellow
___Odorous
___Urgent
___Decreasing in flow
___Reddish
___Burning
___Hesitant
___Incontinent
___Kidney Stones
___Do you wake to urinate?
___How many times?_____

FOR WOMEN:

OBSTETRIC HISTORY

Are you pregnant now? ___Yes ___No ___Unsure Date of last period _____Are you trying to conceive? ___Yes ___No

Check and Provide number:

____Pregnancies ____Miscarriages ____Abortions ____Caesarean ____Vaginal deliveries ____Living Children

____Post Partum Depression ____Toxemia ____Gestational Diabetes ____Baby over 8 lbs

____Breast feeding For how long?_____

MENSTRUAL HISTORY

Age at first period____ Pain: ___yes ___no Clotting: ___yes ___no

Is your menses cycle regular? ___Yes ___No Average number of days in cycle_____ Average days of flow_____

The flow is: ___Normal ___Heavy ___Light

The color is: ___Normal ___Dark ___Purple ___Light Brown ___Brown

Has your period ever skipped? _____ For how long? _____

Use of hormonal contraception: ___Birth Control Pills ___Patch ___Nuva Ring How long? _____

WOMEN'S DISORDERS / HORMONAL IMBALANCE

___Fibrocystic breasts ___Endometriosis ___Fibroids ___Infertility

___Painful Periods ___Heavy periods ___PMS ___Bleeding between periods

___Frequent UTIs ___Frequent yeast infections ___Difficulty with orgasm ___Pain with intercourse

Date: Last Pap Smear _____ /_____ ___normal ___abnormal

Last Mammogram _____ / _____ ___normal ___abnormal Breast Biopsy/ Date _____/_____

Last Bone Density _____/_____ ___within normal range ___high ___low

Are you in menopause? ___yes ___no Age at Menopause_____

___Hot flases ___Mood swings ___Concentration/Memory Problems ___Vaginal Dryness

___Decreased Libido ___Heavy bleeding ___Joint pain ___Headaches ___Weight gain

___Loss of bladder control ___Palpitations

FOR MEN:

Have you had a PSA done? ___yes ___no

PSA level: ___0-2 ___2-4 ___4-10 ___>10 ___Prostate enlargement ___Prostate Cancer

___Change in Libido ___Impotence ___Difficulty obtaining an erection ___Difficulty maintaining an erection

___Premature ejaculation ___Difficulty with orgasm ___Pain or welling of testicles ___Cold or numbness of testicles

___Decreased mental focus ___Decreased mood ___Loss of muscle mass

Have you sought medical intervention for erectile dysfunction?_____

What treatments and have they been successful?_____

Previous Medical Diagnosis (*Please check all that apply):*

Condition	*Date Diagnosed*	*Condition*	*Date Diagnosed*	*Condition*	*Date Diagnosed*
___Diabetes	_____/_____	___High Triglycerides	_____/_____	___Seizures	_____/_____
___Insulin Resistance	_____/_____	___Hepatitis	_____/_____	___HIV	_____/_____
___Metabolic Syndrome	_____/_____	___Mild Cognitive Impairment	_____/_____	___Autoimmune Disorder	_____/_____
___Hypothyroid	_____/_____	___Alzheimer's Disease	____/_____	Type_____	_____/_____
___Hyperthyroid	_____/_____	___Parkinson's Disease	_____/_____	___Cancer_____	_____/_____
___Heart Disease	_____/_____	___ADD/ADHD	_____/_____	Type_____	_____/_____
___High Cholesterol	_____/_____	___Bleeding disorder	_____/_____	___Other_____	_____/_____

Surgeries and Significant Injuries:

_____Date_____

_____Date_____

_____Date_____

Chronic Illnesses:

_____ Date of onset_____Duration_____

_____ Date of onset_____Duration_____

Family History:

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent	Other Relative
Age - if still alive						
Age - when deceased						
Heart Disease						
Stroke						
Hypertension						
Cancer (state type)						
Diabetes						
Obesity						
Autoimmune Diseases						
Inflammatory Arthritis						
Osteoporosis						
Asthma						
Allergies						
Dementia						
Parkinson's Disease						
Alzheimer's Disease						
Genetic Disorders						
Depression						
Other Mental Illness						
Substance or alcohol abuse						
Other						

MEDICATIONS

Current Medications:

Name of Drug	Dose	Taken for How Long?	Reason for Use

Previous / Discontinued Medications:

Name of Drug	Dose	Taken for How Long? When Stopped?	Reason for Use

Supplements:

Name of Supplement	Dose	Taken for How Long?	Reason for Use

Allergies (to medicine, food, environmental allergens):

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have your medications or supplements ever caused unusual side effects or problems? ___yes ___no

Describe:_____

Prolonged or regular use: ___NSAIDS (Advil, Aleve, etc) ___Aspirin ___Tylenol
___Acid Blocking Drugs (Tagamet, Zantac, Prilosec etc)
___Antibiotics _____ Frequent antibiotics >3 times/year _____long term antibiotics
___Steroids (prednisone, nasal allergy inhalers)
___Cortisone shots for pain

Date of Last Physical: _____/_____/_____

Name of Physician: _____

Date of Last Laboratory Blood Test: _____/_____/_____

Abnormal or out of range blood results? ___yes ___no

Describe_____

Date of last Dental Exam: _____/_____/_____

Please check
___ Silver Mercury fillings How many? ____
___ Root canals ___ Implants ___ Tooth pain ___ Bleeding gums
___ Gingivitis ___ Problems with chewing

Do you floss regularly? ___ yes ___ no

Describe any dental health issues_____

Nutrition

Have you ever had a nutrition consultation? ___yes ___no

Have you made any changes in your eating habits because of your health? ___yes ___no Describe_____

Do you currently follow a special diet or nutritional program? ___yes ___no

Check all that apply:

___low fat ___low carb ___high protein ___low sodium ___diabetic ___no diary

___no wheat ___gluten restricted ___vegetarian ___vegan ___pescatarian

___other restrictions (describe):_____

___Specific Program for weight/nutrition management:_____

Height _____ Current Weight _____ Desired Weight _____

Highest adult weight _____ Lowest adult weight _____ Does weight fluctuate > 10 lbs? ___yes ___no

How often do you weigh yourself: ___daily ___weekly ___Monthly ___rarely ___never

Do you avoid any particular foods? ___yes ___no Describe_____

If you could eat only a few foods, what would they be? _____

Do you ever have food cravings? ___yes ___no Describe_____

Do you use spices in your food? ___yes ___no Describe_____

How many servings of fish do you eat weekly? _____

What do you eat on a typical day?

Breakfast _____

Lunch _____

Dinner_____

Snacks_____

Do you grocery shop? ___yes ___no If not, who does the shopping? _____

Do you read food labels? ___yes ___no

Do you cook? ___yes ___no If not, who does the cooking? _____

How many meals do you eat out per week? ___0-1 ___2-3 ___4-5 ___>5

Check all that apply to your current lifestyle and eating habits:

___fast eater ___erratic eating pattern ___eat too much ___dislike healthy food

___time constraints ___eat > 50% of meals out ___travel frequently ___non-availability of healthy food

___do not cook/plan meals ___rely on convenience food ___poor snack choices ___love to eat

___eat because I have to ___struggle with eating issues ___emotional eater ___eat more under stress

___eat less under stress ___don't care to cook ___eat in the middle of night ___confused about nutrition advice

___constrained by eating habits/diet of other household members / significant other

The most important diet improvement I could make is_____

LIFESTYLE

Smoking

Currently smoking: ___No ___Yes How many years_____ Packs per day_____ Attempts to quit _____

Previous Smoking: ___No ___Yes How many years _____ Packs per day _____

Second Hand Smoke Exposure? _____

Alcohol Intake

How many drinks currently per week? *1 drink = 5 oz wine, 12 oz beer, 1.5 oz spirits*

___ None *(if none skip to other substances*) ___ 1-3 ____4-6 ____ 7-10 ___ >10

Days with alcohol per week _____

Previous alcohol intake? ___none ___ mild ___ moderate ___ high Days per week _____

Have you ever been told you should cut down on your alcohol intake? ___ no ___ yes

Do you get annoyed when people ask you about your drinking? ___ no ___ yes

Do you ever feel guilty about your alcohol consumption? ___ no ___yes

Do you ever take an eye-opener? ___ no ___ yes

Other Substances

Caffeine intake: ___none ___coffee ___tea Cups per day: ___1 ___ 2-4 ___ > 4

Caffeinated Soda or Diet Soda Intake 120z can/bottle per day: ___ none ___ 1 ___2-3 ___>3

List favorite type of soda_____

Are you currently using any recreational drugs? ___no ___ yes Type:_____

Have you ever used IV or inhaled recreational drugs? ___ no ___ yes

Exercise *Please list your current exercise program:*

Activity	Type	Frequency per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, etc)			
Sports or leisure (golf, tennis, volleyball, surfing, etc)			

Rate your level of motivation for including exercise in your life ___low ___ medium ___ high

List problems that limit activity _____

Do you feel unusually fatigued after exercise? ___ no ___ yes

If yes, describe _____

Do you usually sweat when exercising? ___ yes ___ no

Sleep:

Average number of hours you sleep per night: _____

Do you have trouble falling asleep? ___ no ___ yes How many minutes does it take to fall asleep? _____

Do you wake during the night? ___ no ___ yes How many times? ____

Can you easily fall back asleep? ___no ____yes How long do you stay awake? _____

How many nights per week do you have trouble with insomnia? _____

Do you snore? ___ no ___ yes

Do you use sleep aids? ___ no ___ yes Describe _____

Do you feel rested upon awakening? ___ no ___ yes

Stress:

Do you feel you have an excessive amount of stress in your life? ___yes ___ no

Do you feel you can easily handle the stress in your life? ___ yes ___ no

Do you have worsening symptoms under stress? ___headaches ____joint pain ____ muscle aches

___ Stomach aches ____ changes in bowels ____ difficult sleep _____fatigue _____ ringing ears _____other

Daily Stressors: Rate on a scale of 1-10

Work/School _____ Family _____ Spouse/Other _____ Social _____ Finances _____ Health _____ Other _____

Have you ever sought counseling? ___ yes ___ no Are you currently in therapy? ___yes ___ no

Do you practice a meditation or relaxation technique? ___yes ___ no How often? _____

Check all that apply: ___Yoga ___ Meditation ___Imagery ___Breathing ___Tai Chi ___Prayer ____Other

Do you feel that stress is presently reducing the quality of your life? ____ yes ____no

Relationships

Marital Status: ___ Single ___ Married ___ Divorced ___ Gay/Lesbian ___ Long Term Partnership ___Widow/er

List Children

Child's Name Age Gender Living in Household?

_____

_____

_____

_____

_____

_____

Who live in the household? Number_____ Names_____

Resources of emotional support: *Check all that apply*

___ Spouse/Partner ___ Family ___Friends ___ Religious/Spiritual ___ Pets ___ Other

Emotional / Spiritual

Overall how have things been going for you? *Not very well ---------- Very well*

	N.A.	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
Overall											
At school											
In your job											
In your social life											
With close friends											
With your attitude / outlook											
With your boyfriend/girlfriend											
With your children											
With your parents											
With your spouse											
With sex											

Rate these statements *Not True ---------- Very True*

	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
My life has meaning and purpose.										
I am happy.										
I feel at peace.										
I have joy in my life.										
I like the work that I do.										
I feel as vital as I did a year ago.										
I spend the majority of my time and money to fulfill obligations and responsibilities.										
I am hopeful about the future.										

Have you experienced major losses in your life? Please describe _____

Have you ever been abused, a victim of crime, or experienced a significant trauma? ___ yes ___ no

Would you describe your childhood experience as happy and secure? ___ yes ___ no

What are the activities you do for your own enjoyment? _____

How often? _____

What do you do to feed your soul? _____

Do you have a spiritual practice? Please describe_____

Do you belong to a spiritual or religious group? _____ Please describe _____

How involved / how important is this group/practice to you? _____

Thank you for sharing this important part of who you are!