Feng Hong, L.Ac.
893 High St Suite J
Worthington, OH 43085
(614) 259-7188

Please complete the entire form so that we may address your health concerns from a whole body perspective. Your information will be kept confidential. Thank you and we look forward to working with you!

Personal Information

Name: _____

Date of Birth: _____ Birth Sex: ☐ Male ☐ Female

Street: _____ Cell Phone #: _____

City: _____ State: _____ Zip: _____ Second Phone #: _____

Email Address: _____ Allow email/mail/phone contact by us? ☐ Yes ☐ No

Relationship Status: ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Emergency Contact: _____ Relationship: _____ Phone #: _____

If under 18, name of person responsible for your account: _____

Primary Care Physician: _____ Phone #: _____

Health Insurance Provider: _____ ID #: _____ Group #: _____

Name of Insured: _____

Secondary health insurance provider if any: _____ ID #: _____

Group #: _____ Name of Insured: _____

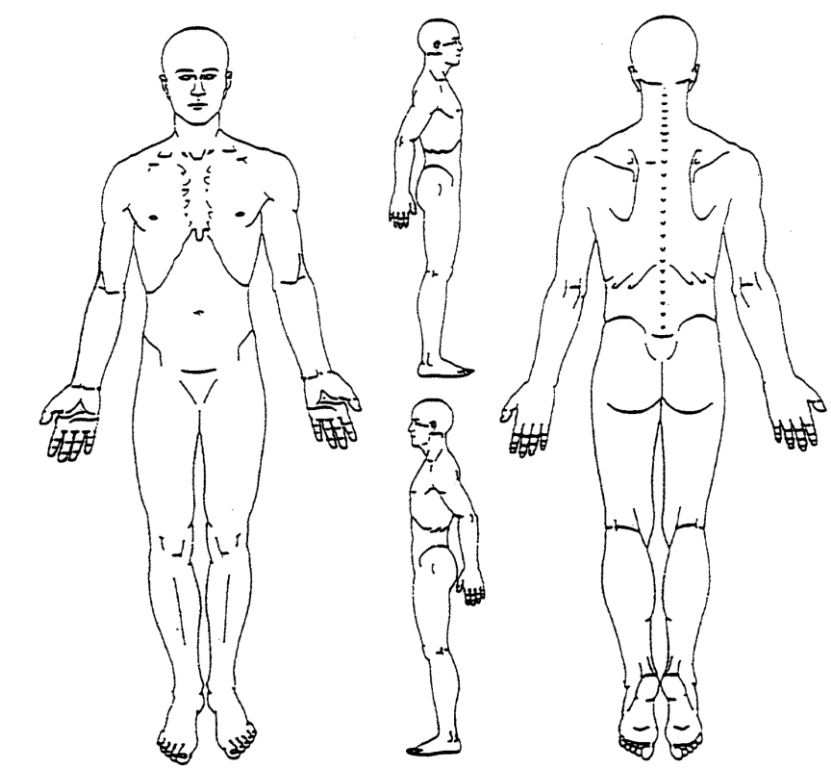
How did you find out about us? _____

Major Health Complaint(s)

Please identify your reason for visit today and any other health concerns.

Concerns	For how long?	Previous diagnosis?	Previous treatments and outcomes
Reason for visit today:			
Other health concern:			
Other health concern:			

For pain condition, please indicate on the diagram your areas of pain and check all that apply to the pain.



PAIN IS:
__ Constant
__ Comes and goes
__ Moves around
__ Tingling/numbness
__ Stabbing/sharp
__ Throbbing
__ Dull/achy
__ Radiating
__ Other _____

PAIN GETS WORSE WITH:
__ Cold
__ Heat
__ Movement
__ Sitting / standing
__ Rainy weather

PAIN IMPROVES WITH:
__ Cold
__ Heat
__ Massage / pressure
__ Movement
__ Rest

PLEASE RATE YOUR PAIN: Mild <- 1
2 3 4 5 6 7 8 9 10 ->
Most severe: _____

Personal Health History

Please list all the illnesses or conditions which you currently have or have had in the past including childhood.

Illnesses, Diseases and Surgeries:	
Medications (prescription, over the counter, vitamins, supplements and herbs):	
Significant Trauma (car accident, injury, fracture, etc.):	

Allergies (food, drug, medication or environmental factors which you are sensitive or allergic to):	

Have you had acupuncture before? ☐ Yes ☐ No

Please indicate if any of the following pertain to you:

☐ Hepatitis ☐ HIV ☐ Diabetes ☐High Blood Pressure ☐ Seizures ☐ Pacemaker ☐ Anticoagulant Medication

Family Health History

Check illnesses which have occurred in any of your blood relatives and specify family member.

☐ Alcohol/Drug Abuse _____ ☐ Heart Disease _____

☐ Asthma/Allergies _____ ☐ Hypertension _____

☐ Cancer _____ ☐ Miscarriage _____

☐ Depression/Mental Illness _____ ☐ Osteoporosis _____

☐ Diabetes _____ ☐ Stroke _____

☐ Other: _____

Lifestyle

Your height: _____'_____" Current weight: _____lbs

Please rate your energy level, Lowest <- 1 2 3 4 5 6 7 8 9 10 -> Highest: _____

Please rate your stress level, Lowest <- 1 2 3 4 5 6 7 8 9 10 -> Highest: _____

Please list your primary sources of stress: _____

Occupation: _____ Employment status: _____

Do you exercise? ☐ Yes ☐ No Explain: _____

Do you smoke? ☐ Yes ☐ No If yes, how many per day? _____ For how long? _____

Glasses of water per day: _____ Cups of coffee per day: _____ Alcoholic beverages per week: _____

Are you a vegetarian? ☐ Yes ☐ No Explain: _____

Foods you tend to crave: _____

How frequent are your bowel movements? _____

Are your bowel movements: ☐ Well-formed ☐ Loose ☐ Small pebbles ☐ Easy to pass ☐ Difficult to pass

How many hours of sleep do you get average nights? _____

Do you have difficulty with: ☐ Falling asleep ☐ Staying asleep ☐ Vivid dreams ☐ Waking not rested

☐ Interrupted sleep: When and why do you wake up? _____

Personal Health Profile

Please check the following symptoms that you have experienced in the past 3-6 months.

Qi, Blood, Yin, Yang

__ catches colds easily or frequently
__ cold feet
__ cold hands
__ fatigue / low energy
__ feel worse after exercise
__ feverish in the afternoon or flushes
__ general weakness
__ heat sensations in hands, feet or chest
__ hot flashes
__ insomnia
__ night sweats
__ sweats easily
__ thirst at night

SP

__ abdominal bloating and / or gas after eating
__ bruise easily
__ diarrhea
__ fatigue after meal
__ general feeling of heaviness in body
__ hemorrhoids
__ hernia
__ loose stools
__ lack of appetite
__ mental sluggishness or fogginess
__ nausea
__ over-thinking or worry
__ prolapsed organs
__ snoring
__ swollen feet, hands or joints
__ weight gain / loss

ST

__ bad breath
__ bleeding, swollen or painful gums
__ constipation
__ large appetite
__ heartburn / acid reflux
__ mouth sores (canker or cold sores)
__ stomach pain
__ vomiting

HT / SI

__ agitation / fidgeting
__ anxiety
__ chest pain
__ mental confusion
__ nightmares
__ palpitations
__ restlessness
__ sores on tip of tongue
__ varicose veins
__ wake unrefreshed in morning

LU/LI

__ allergies
__ alternating fever & chills
__ cough
__ dry mouth, throat, nose
__ dry skin
__ nasal discharge
__ nose bleeds
__ shortness of breath
__ sinus congestion
__ sadness or grief
__ sneezing
__ sore throat
__ stiff neck/ shoulders

LR / GB

__ belching
__ bitter taste in mouth
__ blurred vision
__ brittle hair or nails
__ convulsions / seizures
__ depression
__ diarrhea alternating with constipation
__ difficulty swallowing
__ discomfort in rib cage
__ dizziness
__ feel better after exercise
__ feeling of a lump in throat
__ Irritability / get angry easily
__ headache at the top of head
__ muscle spasms, twitching, cramping
__ numbness of hands and feet
__ red, sore or dry eyes
__ skin rashes
__ tight feeling in chest

KI / BL

__ fear or easily startled
__ frequent urination
__ get up more than one time at night to urinate
__ hair loss
__ hearing issues
__ loose teeth
__ low back soreness or pain
__ low libido
__ memory problems
__ low pitched ringing in ears
__ sore, cold or weak knees

For Men

Any concerns you may have with your sexual function or libido:

_____

For Women

Are you pregnant? ☐ Yes, for how many months? _____ ☐ No ☐ Maybe

Method of birth control? _____ Number of pregnancies: _____ Births: _____

Age of first menses: _____ Date of last menses: _____

Typical length of menses (Number of days of flow): _____

Typical length of cycle (From the 1st day of one cycle to 1st day of the next): _____

Please list any issues you may have before or during your menses (abnormal amounts, irregular cycles, clotting, pain…):_____

Please list any gynecological symptoms or diseases you have:

_____

Any concerns you may have with your sexual function or libido:

_____

OFFICE POLICY

Buckeye Acupuncture is committed to providing the best care for our patients. Payment is expected at the time of service and can be made by cash, check, QuickPay or credit card. If your check is returned by your bank unpaid, there will be a $25.00 returned check fee. If you miss your appointment with no advance notice, you will be charged for the appointment amount after the second occurrence.

All of the above information is accurate to the best of my knowledge. By signing this consent, I am agreeing to receive treatment by Buckeye Acupuncture, to keep all set appointments or informing the clinic of necessary cancellations per the clinic policy. I have also received a copy and had chance to review Buckeye Acupuncture's Notice of Privacy Practices.

Patient Signature: _____ Date: _____

(or Patient representative) (Indicate relationship if signing for patient)

INFORMED CONSENT

I understand that I am the decision maker for my health care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that patients are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an obstetrician, and that patients seeking adjunctive cancer support are under the care of an oncologist. I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: physical measures and rest, over-the-counter pain relievers, medical care with prescription drugs, physical therapy, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Feng Hong, L.Ac. and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for Feng Hong, L.Ac., including those working at Buckeye Acupuncture or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Gua-Sha, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; dizziness or fainting, and aggravation of preexisting symptoms. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, such as pneumothorax. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

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. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue. I understand that some herbs may be inappropriate during pregnancy. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must fully inform, and continue to inform, this clinic of any medical history (including pregnancy and nursing), family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I will immediately notify this clinic of any unanticipated or unpleasant effects.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consents to treatment and policies, I have been explained about the risks and benefits of acupuncture, and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. 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.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

(or Patient representative) (Indicate relationship if signing for patient)

BUCKEYE ACUPUNCTURE

INFORMED CONSENT

[For Microneedling (Collagen Induction Therapy) Only]

I consent to the treatment of microneedling to be carried out upon myself. The microneedling treatment allows for controlled induction of growth factor serums, or hyaluronic acid, into the skin's self-repair process by creating micro injuries in the skin. These injuries stimulate new collagen production without the risk of permanent scaring. The result is smoother, firmer and younger looking skin. The skin needling treatments are performed in a safe and precise manner with a sterile needle head and are usually completed in 30-60 minutes.

I understand the following conditions are Absolute Contraindications of microneedling: scleroderma, collagen vascular disease, dermatological diseases affecting the face (i.e. porphyria), rosacea, blood clotting problems, platelet abnormalities, anticoagulation therapy (e.g. Warfarin), facial cancer, past and present, chemotherapy, steroid therapy, immune-suppression, diabetes, cardiac abnormalities and other chronic conditions, active bacterial or fungal infections, scars less than 6 months old, Accutane within 6 months and Botox/facial fillers in the past 2-4 weeks. I understand treatment is not recommended for patients who are pregnant or nursing, and should also proceed with Precautions in cases of: keloid or raised scarring, eczema, psoriasis, actinic keratosis, and herpes simplex.

I am also aware of possible Side Effects can include: Skin will be pink or red and may feel warm, like mild sunburn, tight and itchy, which usually subside in 12 to 24 hours; Minor flaking or dryness of the skin, with scab formation in rare cases; Crusting, discomfort, bruising and swelling may occur; Pinpoint bleeding; Possible cold sore flare if you have a history of outbreaks; Freckles may lighten temporarily or permanently disappear in treated areas; Infection is rare, but if you see any signs of tender redness or puss, notify the clinic immediately; Hyperpigmentation (darkening of the skin) rarely occurs and usually resolves itself after a month; Permanent scarring (less than 1%) is extremely rare. I also accept the risk of unforeseen complications that may not have been discussed and which may result from this treatment.

I have been explained about the treatment, procedure, indications, expected results and possible side effects. Although microneedling is usually effective, I understand that no guarantees can be made concerning the results in my case, as with all healthcare approaches. I agree that this procedure is being performed for cosmetic reasons and I am undergoing treatment of my own free will.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consents to treatment and policies, I have been explained about the risks and benefits of microneedling, and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. 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.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

(or Patient representative) (Indicate relationship if signing for patient)

NOTICE OF PRIVACY PRACTICES

This notice describes how your personal health information may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Privacy Pledge: Buckeye Acupuncture is committed to full compliance with federal and state laws and regulations ensuring the privacy and confidentiality of our patients' and clients' personal health information; the staff will make every effort to respect your privacy and keep confidential health information entrusted to us.

Our Duties: We are required by law to maintain the privacy of your health information, to provide you with this notice of our legal duties and our privacy practices, and to abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notice in accordance with federal or state law; any such change will apply to all of your information in our files.

Use and Disclosures of Health Information with Your Consent: Patients and clients will be asked to consent to the use or disclosure of your protected health information by agreeing to allow Buckeye Acupuncture staff to:

- Use your health information within the clinic or disclose your health information to another health care provider or facility for the purpose of diagnosis, assessment and treatment of your condition.
- Use your health information within the clinic or disclose your examination, treatment and billing records to another party such as an insurance carrier, HMO or your employer for the purpose of receiving payment for services rendered to you.
- Use your health information, examination, treatment and billing records for quality control or other administrative purposes to efficiently and effectively operate the practice.
- Use your personal health information to contact you by telephone, mail or e-mail with appointment reminders, newsletters, information about treatment alternatives, or other health related information that may be of interest to you as well as sending a thank-you to the person who referred you. If not at home to receive an appointment reminder, a message may be left on your answering machine.

Required or Permitted Use and Disclosures without Your Consent: Use or disclosure of your health information without your consent may be required or permitted in some circumstances, including but not limited to: 1) The extent that we are required or permitted to do so by applicable federal or state laws; 2) A public health authority for a wide range of public health activities when authorized to collect or receive your health information under federal or state law; 3) An appropriate government authority if there is reason to believe you are the victim of abuse, neglect or domestic violence; 4) Federal or state health care system and government benefit program oversight activities; 5) A response to a court order, or in response to a subpoena, discovery request or other lawful purpose; 6) Law enforcement officials when required to report certain types of wounds or physical injuries, or to comply with court orders, a grand jury subpoena or administrative requests; 7) An appropriate law enforcement authority if the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of the person or the public; 8) A correctional institution if we provide health care services to you as an inmate; 9)Emergent care situations; and 10) Providing care to you that is related to a work-place injury to the extent necessary to comply with Ohio's worker's compensation laws.

The Health Care Information Rights of Our Patients and Clients Include:

- Your Right to Revoke Consent: You may revoke your consent to use or disclose your health information at any time; however, your revocation must be in writing; there are two circumstances under which we will not be able to honor your revocation request: 1) Your health information was released prior to receipt of your request to revoke your consent; and 2) Were you required to give your authorization as a condition for obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.
- Your Right to Limit Uses or Disclosures: You have the right to limit the use or disclosure of your personal health information. To do so you must inform us, in writing, of any health care providers, hospitals, employers, insurers or other individuals or organizations that you do not want us to disclose your health information to. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding on us.
- Your Right to Receive Confidential Communication Regarding Your Health Information: We normally provide information about your health to you in person at the time you receive services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any

reasonable, written request if you would like to receive information about your health or the services that we provide at a place other than your home.

- Your Right to Inspect and Copy Your Health Information: You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files; such requests must be in writing. We may refuse your request, and charge you for retrieval and copying costs, only in accordance with law.
- Your Right to Amend Your Health Information: You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. Amendment requests must be in writing and give us reason to support the change you are asking us to make; however, we are not obligated to comply with your request if it is judged to be unreasonable.
- Your Right to Receive an Accounting of the Disclosures We Have Made of Your Records: You have the right to submit a written request for an accounting of the disclosures we have made of your health information for the last six years before the date of your request. By law, such accounting requests will include all disclosures made except for those that: 1) Are required for your treatment, to obtain payment for your services or to operate our practice; 2) Were made to you; 3) We are required or permitted to make without your consent or authorization; 4) Were disclosed with your written consent; 5) Were necessary to maintain a facility directory of individuals involved with your care; 6)Were disclosed for national security or intelligence purposes; or 7) Were made to correctional or law enforcement officers.
- Your Right to Obtain a Paper Copy of This Notice: You may request a copy of this notice at any time.
- Your Right to Complain: You may complain to us or the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to do so and will not take any action against you if you do file a complaint. For further information about our privacy policies and practices, to express a concern or to file a complaint, please contact Buckeye Acupuncture, 893 High St, Ste J, Worthington, OH 43085.

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize Buckeye Acupuncture the use or disclosure of my individually identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information (please print):

_____

_____

_____

I acknowledge that I have been provided access to Buckeye Acupuncture's "Notice of Privacy Practices". By signing below, I give consent to Buckeye Acupuncture staff to disclose my personal health information as noted above.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

(or Patient representative) (Indicate relationship if signing for patient)