SUNDO ACUPUNCTURE
326 Broad Ave
Leonia NJ 07605
(917) 593-3744

PATIENT INFORMATION

Today's Date:	

Legal Name:		Date of Birth:	

(please print) Last First

Age:		Sex:	M / F	E-mail:	

Cell Phone:		Home Phone:	

Mailing Address:	

City:		State:		Zip:	

Employer:		Occupation:	

Emergency Contact:		Phone:	

Name Relationship

Social Security #:		Referred by:	

INSURANCE INFORMATION

Policy Holder's Name:		Date of Birth:	

Policy Holder's Mailing Address: (if different from above)	

Insurance Company:		Member ID:	

Relationship to Insured:	self / spouse / child	Ins. Phone # (to check eligibility) :	

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize Jang Hun (Michael) Lee, L.Ac. to release information regarding my treatment or examination rendered to me for medical care to my insurance company(s) or its representatives. I also authorize payment to be made directly to Jang Hun (Michael) Lee, L.Ac. in the amount due for all medical charges for myself or my eligible dependents. I understand that I am financially responsible for any amounts not covered or paid by my insurance company(s).

Signature:		Date:	

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HEALTH HISTORY

Chief Complaint(s):	

Have you received acupuncture / herbal medicine before?	Y / N	**Height :**	**Weight:**

MEDICAL HISTORY: (check all that apply)

	Allergies		Heart Disease
	Anemia		Kidney Disease
	Asthma		Mental Illness/ Psychiatric Disorder
	Back Problems		Seizures
	Cancer		Surgeries
	Diabetes		Thyroid Disease
	Hepatitis		Accidents or significant Trauma
	High Blood Pressure		Other:

PLEASE LIST ALL MEDICATIONS/ SUPPLEMENTS CURRENTLY TAKING:

_____

_____

CURRENT GENERAL HEALTH INDICATORS: (Check all that apply)

	Decreased appetite		Shoulder pain		Muscle spasms/ twitching
	Increased appetite		Localized weakness		PMS
	Disturbed sleep		Decreased sex drive		Urinary problems
	Fatigue		Fever		Headaches
	Poor coordination		Sweating Easily		Indigestion
	Weight gain		Edema		Constipation
	Weight loss		Gas/ bloating		Diarrhea
	Cold hands / feet		Restlessness		Skin problems
	Night sweats		Tinnitus		Vision problems
	Palpitations		Easily Irritated		Neck pain
	Hot flashes		Recent Injury or trauma		Nasal problems

FOR WOMEN:

Are you currently pregnant? Yes / No Are you trying to conceive? Yes / No History of miscarriage? Yes / No	Average cycle is every _____ days and lasts _____ days. It is heaviest at _____ and the color tends to be_____ Age of first menses_____ Age when menses stopped_____

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ACUPUNCTURE INFORMED CONSENT

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 the acupuncturist named below.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, electrical stimulation, Tui-Na, herbal medicine, and nutritional counseling.

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, and dizziness or fainting. 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.

By signing below, I show that I have read and understand the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had the 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.

Patient Signature_____Date_____