

REGISTRATION
(Please print)

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PATIENT INFORMATION

Name: _____ Phone: Home _____ Work/Cell _____
Address: _____ City: _____ State: _____ ZIP: _____
Email: _____ Age: _____ Date of Birth: _____ Gender: M / F
Social Security #: _____ Family Physician: _____ Referred by: _____
Employer Name & Address: _____ Occupation: _____
In emergency, notify: _____ Relation to Patient: _____
Marital Status: _____ How did you hear about us? _____

INSURANCE INFORMATION

Person responsible for account: _____ Relation to Patient: _____ Birth date: _____
Address (if different from patient's): _____ City: _____ State: _____ ZIP: _____
Social Security #: _____ Phone: H _____ W _____
Insurance Company: _____ Policy #: _____
Contract #: _____ Group #: _____ Subscriber #: _____
Is your condition related to employment? Yes No Is your condition related to an auto accident? Yes No

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have (has) insurance coverage with _____ and assign directly to Chunlin Gao, L.Ac. 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 Chunlin Gao, L.Ac. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

ACUPUNCTURE CONSENT FORM

I, _____ hereby authorize Chunlin Gao, L.Ac. to perform acupuncture and other specific procedures deemed necessary to facilitate my diagnosis and treatment. I recognize the potential risks and benefits of these procedures. I also understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. I hereby release Chunlin Gao, L.Ac. from any and all liability which may occur in connection with acupuncture treatment, except for failure to perform the procedures with appropriate medical care.

Signature

Date

HEALTH HISTORY

Have you ever received acupuncture or oriental medicine treatments before? Yes No

What are your main health concerns you would like help with at this time? _____

How long ago did this problem begin? _____

To what extent does this problem interfere with your daily activities? (work, sleep, sex) _____

Have you been given a diagnosis for this problem? If so, what? _____

What kinds of treatments have you tried? _____

PAST MEDICAL HISTORY

Cancer ____ Diabetes ____ Hepatitis ____ High Blood Pressure ____ Heart Disease ____

Rheumatic Fever ____ Thyroid Disease ____ Seizures ____ Other _____

Surgeries (Type and date) _____

Significant trauma (auto accident, falls, etc.) _____

FAMILY HISTORY

Cancer ____ Diabetes ____ High Blood Pressure ____ Heart Disease ____ Stroke ____

Seizures ____ Asthma ____ Allergies ____ Arthritis ____ Migraines ____ Other _____

MEDICATIONS

Drugs _____

Vitamins _____

Herbs _____

ALLERGIES

Drugs _____

Foods _____

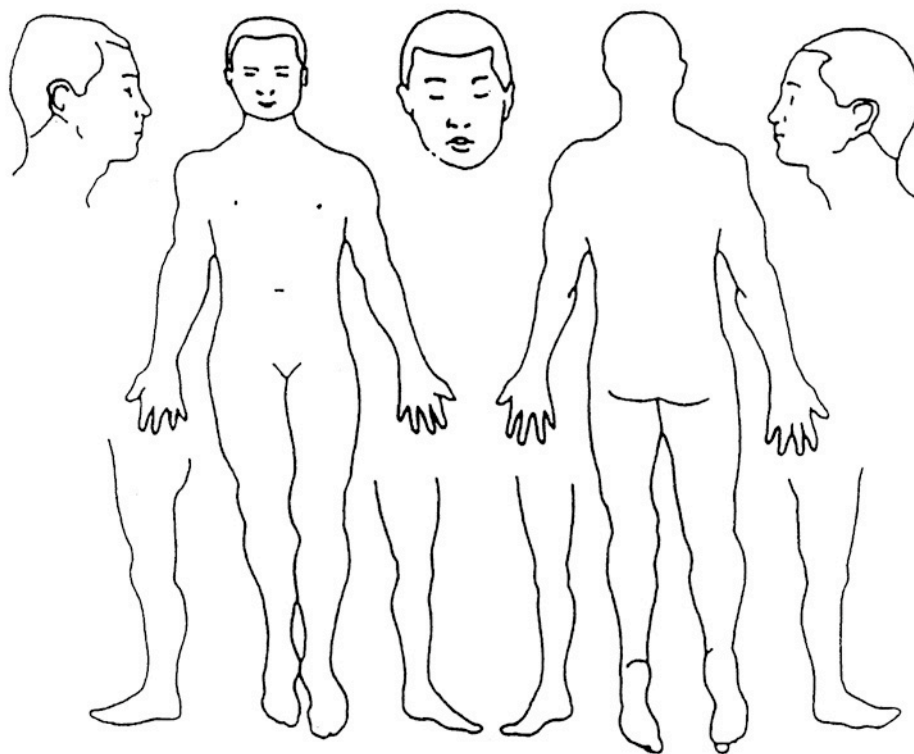
Chemicals _____

HEALTH HABITS

Caffeine _____ Tobacco _____ Drugs _____ Cigarettes _____

Please note the degree of severity of your problem now:

No problem | _____ | Worst pain imaginable



COMMENTS: (Please tell us any other problems you would like to discuss) _____

Signature

Date

GENERAL:

- Chills
- Fevers
- Hot Flashes
- Sweat easily
- Night sweats
- Fatigue
- Sudden energy drop?
What time of day _____
- Cravings
- Poor sleeping

SKIN AND HAIR:

- Rashes
- Itching
- Pimples
- Eczema
- Herpes
- Loss of hair
- Other hair or skin
problems _____

**HEAD, EYES, EARS,
NOSE, AND THROAT:**

- Dizziness
- Migraines
- Headaches, where and
when _____
- Poor vision
- Eye strain
- Blurry vision
- Eye pain
- Spots in front of eyes
- Ringing in ears
- Poor hearing
- Earaches
- Sinus problems
- Nosebleeds
- Grinding teeth
- Jaw clicks
- Facial pain
- Sore throat
- Sores on lips or tongue
- Other head problems:

CARDIOVASCULAR:

- High blood pressure
- Low blood pressure
- Irregular heartbeat

- Rapid heartbeat
- Cold hands or feet
- Swelling of hands or
ankles
- Chest pain
- Other heart or
circulatory problems:

RESPIRATORY:

- Cough
- Coughing blood
- Production of phlegm
- Difficulty in breathing
- Bronchitis
- Pneumonia
- Asthma

GASTROINTESTINAL:

- Poor appetite
- Excessive hunger
- Excessive thirst
- Thirst, no desire to
drink
- Nausea or vomiting
- Belching
- Abdominal pain or
cramps
- Bloating
- Gas
- Constipation
- Chronic laxative use
- Black stools
- Blood in stools
- Hemorrhoids
- Other stomach or
intestinal problems:

GENITO-URINARY:

- Pain on urination
- Urgency to urinate
- Frequent urination
- Unable to hold urine
- Blood in urine
- Impotency
- Sores on genitals
- Do you wake up to
urinate? Yes No
How often? _____

- Any particular color to
your urine? _____

GYNECOLOGICAL:

- Number of pregnancies
- Number of births _____
- Premature births _____
- Miscarriages _____
- Abortions _____
- Age at first menses _____
- Period between
menses _____
- Duration _____
- First date of last
menses _____
- Irregular periods
- Changes in
body/psyche prior to
menstruation
- Vaginal discharge
- Vaginal sores
- Breast lumps

Do you practice birth
control?

What type and for how
long? _____

MUSCULO-SKELETAL:

- Neck pain
- Back pain
- Hand/wrist pain
- Shoulder pain
- Knee pain
- Foot/ankle pain
- Hip pain
- Muscle pains
- Muscle weakness
- Muscle numbness

NEUROPSYCHOLOGICAL:

- Bad temper
 - Depression
 - Anxiety
 - Easily susceptible to
stress
 - Poor memory
 - Loss of balance
 - Seizures
- Have you ever been treated
for emotional problems?