Edward Choi, LAc, MTOM
Inland Empire Acupuncture & Herbs, Inc.

7177 Brockton Avenue, Suite 333 **951-444-8340 (phone)**
Riverside, CA 92506 **ed@ieacupuncture.com(email)**

This is a confidential questionnaire used to develop a treatment plan.

Name: ______________________________ Date of Birth: _______________________ Age: ___

Home Address: ____

City: ________________________________ State: ______ Zip: __________________

Relationship Status: Single( ) Married( ) Partnered( ) Divorced( ) Widowed( ) Other( )

Gender: Male( ) Female( ) In Transition( )Height: __________ Weight: ___________

Cell Phone: ___________________________ Home Phone: _________________________________

Work Phone: __________________________ Email: ______________________________________

Occupation:____

Emergency Contact Name & Phone: ____

Referred by: Google ( ), Yelp ( ), Facebook ( ), Ads ( ), Family / Friend ( ), Other: __________________

Main Reason for Today's Office Visit: ____

If there is any pain please circle(1 = mild, 10 = extreme): 1 2 3 4 5 6 7 8 9 10

Do you have a history of taking anticoagulants or antidepressant medication? Yes( ) No( )

Do you have any allergies? ____

List all medications& Supplements you are currently taking:

Medication	Dosage	How long	Prescribed by
1			
2			
3			
4			
5			
6			
7			
8			

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General Health History (√ Past or Present or both as appropriate)

Past	Present	Condition	Past	Present	Condition
		Abnormal Menstruation			Hepatitis
		Abnormal Weight Loss			High Blood Pressure
		Alcohol/Drug/Tobacco Dependence			High Cholesterol
		Allergies			HIV
		Angina (Chest Pain)			Hospitalizations/Surgical Procedures
		Arthritis/Rheumatoid Arthritis			Infectious Disease
		Artificial Joints			Insomnia
		Asthma			Kidney Disease
		Blood Disorder			Liver Problems
		Breast Lumps			Pacemaker
		Cancer/Tumor			Painful Menstruation
		Convulsions/Seizures			Palpitation/Arrhythmia
		Diabetes			Peptic Ulcer
		Diarrhea/Constipation			Post Menstrual Syndrome
		Digestion Issues			Pregnancy
		Excessive Thirst			Prostate Problems
		Fainting or Dizziness			Seizures
		Fatigue			Sinusitis
		Frequent Urination			Skin Disorder/Issues
		Headache			Stroke
		Heart attack			Thyroid Disease
		Heartburn or Indigestion			Yeast Infection

Family History

Arthritis ( ) Cancer ( ) Diabetes ( ) Heart Diseases ( ) Hypertension ( )
Hyperlipidemia ( ) Lupus ( ) Mental Disorders ( ) Thyroid Disorders ( )
Other: ____

For Women

Have you been diagnosed with:
Fibroids ( ) Endometriosis ( ) Ovarian Cysts ( ) Infertility ( ) Fibrocystic Breasts ( )
Polycystic Ovary Syndrome( )Fibromyalgia ( ) STD's ( )
Other: ____

Patient's Signature: ______________________________ Date: ____________

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ACUPUNCTURE INFORMED CONSENT AND DISCLOSURE

I,________________________________, hereby consent to Edward Choi, a licensed Acupuncturist in the State of California, performing treatment according to the professional standards of the Acupuncture Practice Act of the State of California. This consent is extended to include Mr. Choi's designated assistants and associates. This consent shall extend to remedying any unforeseen conditions or reactions to treatment procedures.

Mr. Choi has discussed with me the treatment of my condition including (1) the nature and purpose of the proposed procedures, (2) the benefits and risks of the proposed procedures, and (3) the benefits and risks of no treatment.

I acknowledge that (1) Mr. Choi is not a physician and that I will always consult my physician with regard to medical conditions, and (2) there are no guarantees, warranties, or representations regarding the success of the treatments and procedures that have been or may be given to me.

I acknowledge that I have been given the opportunity to discuss my condition and proposed treatments and procedures and that all my questions have been answered to my satisfaction, so that I have sufficient information to make an informed decision to undergo the proposed treatments and procedures.

I consent to additional procedures from those described herein that the named acupuncturist and his associates and assistants deem necessary and appropriate during the course of the proposed treatments and procedures. I understand that there are possible side effects to my treatment that may include, but are not limited to, the following:

- ✓ Minor pain or soreness in the treatment areas
- ✓ Transient bruising
- ✓ Infection
- ✓ Needle sickness (dizziness, nausea, fainting)
- ✓ Broken needles
- ✓ Sensations of heat, cold, tingling or numbness
- ✓ Skin irritation or slight bleeding at needle site
- ✓ Generalized fatigue
- ✓ Gastrointestinal disturbance from herbal remedies

I hereby acknowledge that the information described herein has been explained by Mr. Choi, that I have read and fully understand this consent document, and that this consent is given voluntarily and without reservation.

____ ____________________
Signature of Patient/Guardian/Representative Date

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Patient Financial Responsibility

✓ You, as the patient or guardian of the patient, are responsible for the cost of all services rendered.

✓ Insurance may not pay for certain services rendered, which will be the responsibility of the patient. The practitioner will try to notify you in advance of services that may not be covered by insurance, but practitioner's failure to notify in advance will not relieve you of financial responsibility.

✓ If insurance eligibility cannot be verified prior to services being rendered, or if you do not have insurance, then full payment is due prior to treatment.

✓ Deductibles, co-insurance, and co-payments are due at the time of your office visit.

✓ If your health insurance requires a referral or prior authorization you are required to receive that referral or prior authorization before treatment. If a referral or prior authorization is not received before treatment, then full payment for treatment will be due in advance.

I understand my financial responsibility for services rendered.

Print Name: ______________________________

Signature: ______________________________________ Date: _______________