PERSONAL INFORMATION

--------Note: This is a confidential record.

Name: _____

Sex: _____ Birth date: _____ Age: _____

Address: _____

Home Phone: _____ Cell: _____ Email: _____

Preferred method of contact: _____

Occupation: _____ Employed by: _____

Emergency Contact: _____ Phone: _____

Who referred to our office/How did you hear about us ?_____

Have you ever been diagnosed with the following : Hepatitis____ HIVvirus ____ AIDS _____

Are you currently under another physician's care for any medical conditions? (If yes, give your doctor's name AND the medical condition.) _____

Are you currently taking any prescription medication or supplements? If so, please list them:

_____

Have you ever had acupuncture before? _____

Please list any health conditions, if any, that you would like to focus on: _____

_____

What other forms of treatment have you sought? _____

Are you currently experiencing pain? _____

Do you have any allergies? If so, please explain: _____

CONSENT FOR ACUPUNCTURE

I, the undersigned, give my permission and consent to treatment. I fully understand that there is no implied or stated guaranteed of success or effectiveness of a specific or series of treatments.

Patient's Signature _____ Date_____

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Name: _____ Date: _____

In Eastern Medicine it is important to know what type of symptoms a patient has experienced and is currently experiencing in order to most accurately diagnose their pattern.
In the form below, please Indicate with one check any condition that you sometimes experience, use two checks for those which occur often, and three checks for symptoms that are a major concern.

WOOD ELEMENT
☐Headaches
☐Migraines
☐Ringing in the ears
☐Poor eyesight
☐Herpes simplex
☐Warts
☐Eye infections
☐Dry eyes
☐Eczema
☐Shingles
☐Nervousness
☐Convulsion, spasms
☐Irritability
☐Anemia
☐Constipation
☐Halitosis
☐Hemorrhoids
☐Hepatitis
☐Heartburn
☐Ulcers
☐Vomiting
☐Gallstones
☐Indecisiveness
☐Fullness below ribs
☐Shoulder/neck tension
☐Insomnia 11PM - 3 AM

WATER ELEMENT
☐Hearing loss
☐Dizziness
☐Lower back ache/pain
☐Sinus congestion
☐Edema
☐Darkness under the eyes
☐Emotional instability
☐Aversion to cold
☐Hair thinning or loss
☐Premature aging
☐Frequent urination
☐Kidney stones
☐Weakness of legs / knees
☐Asthmatic cough
☐Rapid weight change
☐Loose teeth
☐Reduced sexual energy
☐Thyroid problems
☐Diabetes
☐Perspire very easily

FIRE ELEMENT
☐Dry Scalp
☐Skin eruptions, rashes Cysts,
☐Tumors
☐Ear infections
☐Sore throat, tonsillitis
☐Lymphatic swelling
☐Hot palms and soles
☐Heart palpitations
☐Aversion to heat
☐Bitter taste in mouth
☐Gum problems
☐Nose bleed
☐Facial redness
☐Itching/burning skin
☐Hot hands/feet
☐Thirst
☐Vivid dreaming
☐Dark urine
☐Night sweats

METAL ELEMENT
☐Bronchitis
☐Asthma
☐Shallow breathing
☐Cough
☐Sinus congestion
☐Nasal infections

EARTH ELEMENT
☐Indigestion
☐Flatulence
☐Food allergies
☐Stomach ache
☐Stomach ulcer
☐Diahrrea
☐Anemia
☐Halitosis
☐Sores in mouth
☐Heartburn
☐Strong appetite
☐Weak appetite
☐Nausea
☐Abdominal bloating
☐Low body weight

OTHER
☐Fatigue
☐Athralgia
☐Sciatica / nerve pain
☐Cold hands / feet
☐Tendonitis
☐Bursitis

PAIN (please describe below)
_____
_____
_____

OTHER COMMENTS
_____
_____
_____

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Services and Rates

Balance Initial Treatment with Consultation
(75 minutes) $150

When you come in for your first treatment, Suchin Kang will, together with you, assess all aspects of your physical and emotional health to develop a treatment plan that is right for you. We will determine the best combination of treatment modalities to most effectively achieve your health goals and bring balance and healing to your entire being.

The session will include a combination of at least two of the following treatment modalities :

Acupuncture, Acupressure, Chinese Herb Formulations, Nutritional Supplements, Cupping, Ear Seeds, Pyonex Press Tack needles, Energetic Balancing, Gua Sha, Ice and Heat Therapy, Kinesiology, Life-Style Coaching, Moxibustion, Myofascial Release, Nutritional Coaching, Craniosacral Therapy, Motor Point Stimulation.

Balance Treatment Follow Up
(55 minutes) $125

The session will include a combination of at least two of the following treatment modalities, as determined together by Suchin Kang :

Acupuncture, Acupressure, Chinese Herb Formulations, Nutritional Supplements, Cupping, Ear Seeds, Pyonex Press Tack needles, Energetic Balancing, Gua Sha, Ice and Heat Therapy, Kinesiology, Life-Style Coaching, Moxibustion, Myofascial Release, Nutritional Coaching, Craniosacral Therapy, Motor Point Stimulation.

Any herbs or supplements are an additional cost.

The fees for office services are payable at the time of the visit. For your convenience, we accept cash, check and all major credit cards.

The fees charged at Moonrise Medicine are comparable to those charged by other specialists with similar qualifications in this geographic area.

You are responsible for any charges not covered by insurance. Please bring your insurance card to the initial appointment, and obtain pre-authorization or referral from your primary care provider if needed. Please provide immediate notification if there is any change in your insurance plan.

We ask that you make every effort to arrive on time to your scheduled appointment time. If you are running late, please telephone us as we may have to reschedule your appointment if we cannot accommodate you.

If for any reason you need to cancel an appointment, we require a minimum of 24-hour notice. The fee for canceling any appointment less than 24 hours or missing your appointment is $125, the cost of the appointment itself. We do understand emergencies happen, as such, we appreciate you notifying us as soon as possible.

_____ _____

Signature of Patient or Responsible Party Date

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been offered a copy of this office's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, and that any amended Notice of Privacy Practices will be available at each appointment. I consent to the use or disclosure of my identifiable health information by Suchin Kang, MSTOM, L.Ac., for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

_____ _____

Signature of Patient or Responsible Party Date

Release of Information

In order to facilitate care at a specialist's office and at your request, Suchin Kang, L.Ac. may release information regarding your medical condition and treatment, address, phone number. *This information will not be shared without prior notification to you of both the content and intent for its release.* I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I agree to the release of this information.

_____ _____

Signature of Patient or Responsible Party Date