Ni's Acupuncture Center | CTMA

Date _____

Name_____Home Phone: ( ) _____
Last First Middle Initial

Address: _____ Best Contact Number: ( ) _____

_____Email: _____

What is the **best way** to communicate with you between office visits?

(E-mail, Home, Work, Cell Phone). _____

Is there any place you do **NOT** want us to leave a message? _____

May Ni's Acupuncture Center send you educational/promotional materials such as newsletters via e-mail? Yes No

Occupation _____

Date of Birth ____/ ____/ _____ Sex: M F Height:_____ Weight: _____lbs Single Married

Name of Spouse _____ Closest Relative _____ Phone:( ) _____
If completing this form for another person, what is your relationship to him/her? _____

REFERRED BY : _____

1. Have you ever had Hepatitis? If yes, when _____ Yes No
2. Do you have AIDS or HIV infection? How long? _____ Yes No
3. Have you ever had any surgery? Please list type and year below. Yes No

_____ (Please Use Back Page if Necessary)

4. Have you ever had heart problems or symptoms? Please explain: _____ Yes No

_____

5. Are you taking any medication or pain pills at this time? Please List: Yes No

_____ (Please Use Back Page if Necessary)

6. Are you pregnant? If yes, what month are you in? _____ Yes No
7. Have you had Acupuncture before? For what problem: _____ Yes No
8. Do you have any problems with needles, dizziness, nausea, or fainting? Yes No
9. Reason for your visit:

_____

_____

_____

10. Signature : _____ Date: _____

Ni's Acupuncture Center
Chinese Traditional Medical Association
505 Delannoy Ave
Cocoa FL 32922
Phone: (321)454-9259 Fax: (321)454-9974

CONSENT FORM

I,_____, hereby consent to be treated with acupuncture and herbal medicines by Dr. Sonny Lim, My Phan or Jonathan Lee.

I understand that acupuncture is performed by the insertion of fine needles into specific points on the body with the intent of improving body functions and /or relieving pain. I understand that only pre-sterilized, disposable needles will be used. I further understand that the needles may cause some temporary localized pain, bruising, or light headaches "Moxibustion" a.k.a. heat therapy may also be used and natural herbal formula may be prescribed.

I am in full compliance with the fact that in the event I decide to seek treatment from a health practitioner outside this clinic and patient records need to be transferred, all herbal prescriptions/acupuncture points on the records are copyrighted, the exclusive property of THIS clinic and may not be used without express written permission from THIS clinic. Any request of patient records by me or any other health practitioner I decide to transfer to for purposes of using copyrighted herbal/acupuncture prescriptions of THIS clinic without permission is strictly prohibited.

I accept the fact that there is no guarantee concerning the outcome of my acupuncture or herbal treatments and I understand that I may stop treatment at any time. I also accept that there are NO REFUNDS on any services, including herbal formulas.

Our herbal supplements are for relieving symptoms only. The herbal supplements are not intended to diagnose, cure, prevent or treat any disease.

Payment must be made in full at the time of treatment. We do not handle insurance claims. You may file for possible reimbursement from your insurance company. Please ask the receptionist to include the diagnosis code(s) on your receipt during each visit for insurance purpose

Signature of Patient or Guardian_____Date_____

The employees of Ni's Acupuncture Center and CTMA endeavor to maintain your confidentiality to the best of their ability. If you have any questions or concerns regarding the privacy of your records, please contact the office manager.

NI'S ACUPUNCTURE CENTER
FORM FOR NON-OFFICE VISIT CONSULTATION
(new patients only)

New Patient Consultation: $80

(Please write legibly)

Name:

APPETITE

Do you feel hungry at: Breakfast? _____ Lunchtime? _____ Dinner? _____

How is your ability to taste food? _____

Do you consume a small, moderate, or large amount of food at mealtimes? Explain.

_____

Additional Comments Concerning Appetite: _____

BOWEL MOVEMENT

Do you have a bowel movement at least once a day? Explain. _____

Is the texture of your stools firm and long? Explain. _____

What is the color of your stools? _____

Do you have the feeling of having adequately emptied your bowels?

_____

Additional Comments Concerning Your Bowel Movements: _____

URINATION

Do you urinate at least 5 to 7 times a day? Explain. _____

What is the COLOR of your urine? _____

Do you have (circle one) a small moderate large amount of urine?

Do you have adequate force when urinating? _____

Do you feel abnormally thirsty at times? _____

Do you sweat abnormally? (i.e. Sweat when not performing normal activities) _____

Additional Comments Concerning Urination: _____

***What is the color of your tongue coating? _____

SLEEP PATTERN

Are you able to sleep the entire night without waking up? _____

Do you feel adequately rested upon rising? _____

Additional Comments Concerning Sleep: _____

THE FACE AND FOUR LIMBS

Does your face feel cool and comfortable? _____

Does the back of your hands and feet feel cool? _____

Does the palms of your hands and soles of your feet feel warm? _____

Additional Comments Concerning The Face And Four Limbs: _____

MALE AND FEMALE YANG CHARACTERISTICS

(MALES) Do you have an erection upon rising in the morning? Yes No

(FEMALES) Are your nipples erect upon rising in the morning? Yes No

PAIN

Do you have pains in your:

Back? _____

Legs? _____

Hands? _____

Other Areas In Pain?

_____

_____

_____

OTHER SYMPTOMS OF CONCERN OR SIGNIFICANCE:

*** If you plane to receive herbal medicines from us by mail order, unless already on file, we will need your:

Credit Card Number And Expiration Date:

Current Mailing Address: