Patient Information

Patient Name: _____

Last First Middle

Address: _____

Street City State Zip

Birth Date: _____ Age: _____ Sex: _____

Marital Status: _____

SSN: _____-_____-_____ Occupation: _____

Home Phone: _____ Work Phone: _____

Employer's Name: _____

Address: _____

Person to call in case of emergency: _____

Relationship: _____ Phone: _____

Who refers you to our office: _____ Living Will: Yes[] No[]

Insurance Information

Do you have insurance? Yes[] No[]

Insurance Company: _____ Insured ID: _____

Relationship to insured: Self [] Spouse [] Child [] Others: _____

Secondary Insurance Company: _____

Company Name: _____ Insured ID:_____

Relationship to insured: Self [] Spouse [] Child [] Others: _____

Patient Authorization

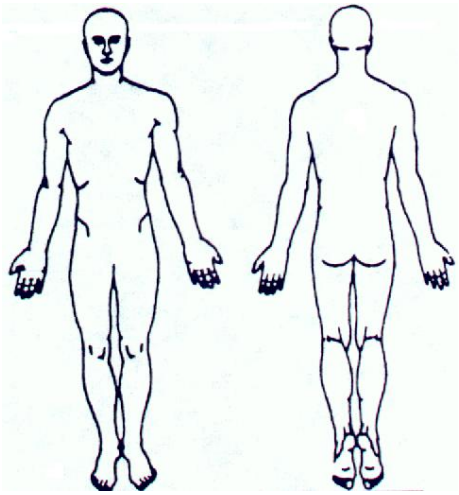
1. ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize direct payment of medical benefits to Dr. Su for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance.
2. AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Dr. Su to release any medical or incidental information that may be necessary for either medical care or in processing application for financial benefits.

Patient/Representative Signature: _____ Date: _____

Patient Medical History

Major Complaint: _____

Please mark the areas of discomfort
Or pain on the figures using the symbol
That describes the feeling:



*** Sharp or Stabbing
ooo Pains or Aching
/// Numbness
vvv Dull

Please mark "X" if you have any the following medical symptoms.

Respiratory & Circulation System

[ ] Coughing
[ ] Running Nose
[ ] Short Breathing
[ ] Sputum
[ ] Chest Pain
[ ] Cold
[ ] Influenza
[ ] Bronchitis
[ ] Asthma
[ ] Palpitation
[ ] Irregular Heart Beat
[ ] Coronary Heart Disease
[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Buerger's Disease
[ ] Problem in blood Vessels

Digestive & Hemopotetic System

[ ] Nausea
[ ] Vomiting
[ ] Gas Distention
[ ] Gastric Hyperactivity
[ ] Hiccup
[ ] Stomachache
[ ] Diarrhea
[ ] Constipation
[ ] Blood in feces
[ ] Gastric Neurosis
[ ] Chronic Gastritis
[ ] Ulcer
[ ] Cholecystitis
[ ] Gallstone
[ ] Jaundice
[ ] Hepatitis
[ ] Cirrhosis
[ ] Anemia
[ ] Thrombocytopenic Purpura
[ ] Hematocytopenia

Urinary & Reproductive System

[ ] Frequent Urination
[ ] Urgency of Micturition
[ ] Incontience of Urinary
[ ] Enuresis
[ ]Urinary Retention
[ ] Dysuria
[ ] Blood Urine
[ ] Nocturia
[ ] Polyuria
[ ] Urethritis
[ ] Prostatitis
[ ] Bladder Infection
[ ] Chronic Nephritis
[ ] Kidney Stone
[ ] Emission
[ ] Impotence
[ ] Sexual Dysfunciton
[ ] Veneral Disease

Nerve & Psychical System

[ ] Dizziness
[ ] Excessive Sweating
[ ] Insomnia
[ ] Headache
[ ] Migraine
[ ] Numbness limbs
[ ] Facial Spasm
[ ] Palsy
[ ] Trigeminal Neuralgia
[ ] Epilepsy
[ ] Stroke
[ ] Hemiplegia
[ ] Intercostal Neualgia
[ ] Sciatica
[ ] Difficult to Balance
[ ] Anxiety
[ ] Tension
[ ] Depression
[ ] Alcoholism
[ ] Use of Narcotics
[ ] Schizophrenia
[ ] Nervousness
[ ] Stress Syndrome

Musculoskeletal System

[ ] Pain in Fingers
[ ] Pain in Wrist

[ ] Arm and hand Pain
[ ] Shoulder Pain
[ ] Neck Pain
[ ] Pain in Ribs
[ ] Pain in Spine
[ ] Leg Pain
[ ] Leg Cramps
[ ] Cervical Spondy Lopathy
[ ] Tennis Elbow
[ ] Carpal Tunnel Syndrome
[ ] Acute Lumbar Sprain
[ ] Chronic Lumbar Muscle Strain
[ ] Knee Arthritis
[ ] Sprain of Ankle Joint

Surgical & Skin Disease

[ ] Hemorrhoid
[ ] Tubercuous Lymphadentis
[ ] Acute or Chronic Mastitis
[ ] Thrombolic Phlegmasia
[ ] Urticaria
[ ] Neurodermatitis
[ ] Herpes
[ ] Cutaneous Pruritus
[ ] Wart
[ ] Anaphylactoid Purpura
[ ] Losing of Hair
[ ] Acne
[ ] Rashes
[ ] Allergic Skin
[ ] Shingles
[ ] Psoriasis

Gynopathy

[ ] Dysmenorrhea
[ ] Amenorrhea
[ ] Menstruation Irregular
[ ] Leukorrhea
[ ] Pelvic Inflammation
[ ] Vulvovaginitis
[ ] P.M.S.
[ ] Menopause Syndrome
[ ] Uterus Fibroid
[ ] Ovarian Cyst
[ ] Breast Cyst
[ ] Vomiting of Pregnancy
[ ] Infertility

Eye, Ear, Nose, & Throat

[ ] Glaucoma
[ ] Acute or Chronic Phanyngitis
[ ] Allergic Rhinitis
[ ] Sinusitis
[ ] Hay Fever
[ ] Epiphora Tinnitus
[ ] Losing Visual Ability
[ ] Vertigo
[ ] Sore Throat

Metabolism, Endocrine & Immunity System

[ ] Diabetes
[ ] Hypertipemia
[ ] Gout
[ ] Simple Obesity
[ ] Hypothyroidism
[ ] Arthritis
[ ] Rheumatic Arthritis
[ ] Over Weight
[ ] Cancer
[ ] HIV

Family History

Has any member of your family ever had the followings?

Illness	Family Member	Illness	
Cancer (type)	_____	Stroke	_____
High Blood Pressure	_____	Mental Disease	_____
Heart Disease	_____	Bleeding Disease	_____
Diabetes	_____	Others	_____

What kind of medication are you currently taking?
Are you allergic to any food, drugs of others?
Do you carry cardiac Pacer?
Do you bleed or have blue marks on skin easily?
Have you been hospitalized in the past year?
If YES, For what?
(Female Only) Menstrual Conditions?
How long does each last?
Color: Dark [] Light []
Quantity: Heavy [] Light []

Su's AcuHerb Clinic
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Consent Form

Name: _____

Address: _____

Tel. Home (_____)_____ Work (_____)_____

I do hereby consent to be treated with acupuncture by an acupuncturist who is licensed to practice acupuncture in the State of Maryland.

I understand that acupuncture is performed by the insertion of needles through the skin, with or without the use of electrical stimulation, with or without the application of heat (moxibustion) and / or other techniques (i.e. cupping, manipulation) at acupuncture points.

I understand that certain adverse side effects may result from treatment. These could include but not limited to light bleeding, bruising or soreness at the insertion site. Fainting or syncope is rare but may occur when a patient is highly anxious, extremely fatigued or hungry.

I understand that this form of treatment is not a substitute for western medical treatment and that if I am under the care of a physician for a particular ailment or condition, I should continue my care until advised differently by my doctor.

The undersigned hereby consents to such treatment and release Dr. Susan C. Su and her employees and agents from any injury, which may result from such treatment.

I have carefully read, and I understand, the foregoing.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian of Minor or POA of Senior Date

_____ _____
Witness Date

I _____ acknowledge that I have received, reviewed, understand and agree to the notice of privacy practices of Dr. Susan Su. Which describes the Practice's polices and procedures regarding the use and disclosure of any of my protected health information created, received, or maintained by the Practice.

____/____/____ _____

Date Signature

_____

Print Name