OASIS ACUPUNCTURE LLC
PATIENT INFORMATION FORM

Name:_____Last 4 digits of SSN_____Today's Date:_____

Date of Birth: _____Age_____Gender: M / F / other Marital Status_____

Address_____City_____State_____Zip_____

Primary Phone Number_____ [ ] Home [ ] Mobile [ ] Work

Secondary Phone Number_____ [ ] Home [ ] Mobile [ ] Work

Email Address_____

Placement of Employment_____Occupation_____

Address_____City_____State_____Zip_____

Please list the family members or other persons, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name_____Relationship_____Telephone #_____

Name_____Relationship_____Telephone #_____

How were you referred to the Clinic? _____

It is the responsibility of the patient to notify OASIS ACUPUNCTURE if any of their information should change. Please inform your Acupuncture Physician, so that she may update your records.

_____ _____

PRINT Patient Name DATE

_____

Patient Signature

OASIS ACUPUNCTURE LLC
PATIENT CONSENT FORM

I hereby consent to the following provisions deemed necessary by **OASIS ACUPUNCTURE LLC**.

Patient's Name: (PLEASE PRINT)_____

A. **Treatment:** Any and all health care and treatment, which may include Acupuncture, herbal formulas, Acupuncture injection, TuiNa, GuaSha, cupping therapy, moxibustion, therapeutic exercises and/or nutritional counseling. I understand that needling, GuaSha, and cupping therapy may cause bruising, neuritis in some cases.
B. **Financial Information:** All professional fees are due in full at the time services are rendered. I hereby acknowledge and accept full responsibility for any and all cost incurred. **OASIS ACUPUNCTURE does not bill insurance or other third-party payers.** Therefore, it is my sole responsibility to request reimbursement from my health insurance plan if I desire reimbursement of costs paid.
C. **Authorization of Compensation:** Payment is made directly to **OASIS ACUPUNCTURE** for the amount due after services have been rendered. Payment can be made by check, major credit cards or cash.
D. **Authorization to Use and Disclose Health Information:** I authorize **OASIS ACUPUNCTURE** to use all of my medical data for education purposes or in cases of disputed credit card transactions. Confidentiality will be maintained.

Patient Signature: _____ Date_____

Witness Signature: _____ Date_____
(OASIS ACUPUNCTURE Representative)

Our **Notice of Privacy Practices** provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The Terms of our notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by _____ Date:_____
Print Name – Patient of Representative

Relationship to Patient (if other than patient): _____Date:_____

Witness: _____Date:_____
Print Name (OASIS ACUPUNCTURE Representative)

OASIS ACUPUNCTURE LLC
NEW PATIENT INTAKE FORM

Patient Name:_____ Age: _____ Today's Date:_____

Date of Birth:_____Gender: M / F / other Height:_____Weight:_____

PRESENT: ___PREGANT ___PACE MAKER ___ SEIZURE ___HIV ___STD ___Covid-19___None

FAMILY HISTORY:

___Asthma	___Heart Diseases	___Seizure	___Cancer: what kind _____
___Allergies	___High Blood Pressure	___Alcoholism	___Abuse: what kind_____
___Diabetes	___Respiratory Disease	___Mental Illness	___None ____Other_____

CHILDHOOD ILLNESS: _____

CHECK ANY OF THE FOLLOWING SYMPTONS WHICH APPLY TO YOU (Now or recent past)

MUSCULOSKELEAL
__Upper back pain
__Lower back pain
__Neck pain__Arm pain
__Shoulder pain
__Joint pain/stiffness
__Walking problems
__Cold/Tingling extremities
__Accident: car / fall /other
__Bone fracture_____

NERVOUS SYSTEM
__Numbness, where_____
__Paralysis, where_____
__Dizziness __Vertigo
__Forgetfulness: long / short term
__Confusion
__Depression __Anxiety
__Fainting
__Convulsions / Seizure
__Headaches__Migraines

CARDIOVASULAR/Pulmonary
__Chest pain ____Palpitation
__Blood pressure: High / Low
__Sweating: daytime / nighttime
__Heart problems ___Lung problems
__Sleep: _____hours/night
__Short of breath __Varicose Veins
__Chill __Fever ___Alternate
__Ankle Swelling __Face puffy
__Energy: High / Low / Moderate

GENITO-URINARY
__Bladder trouble
__Urine: Painful / excessive
__Discolored urine
__Urine leakage
__Nighttime urination
__Blood / stone in the urine
__Intake equal output
__None

EENT
__Vision __Dental problems
__Jaw clicking / popping
__TMJ __Difficult chewing
__Earaches ___ Sore throat
__Hearing difficulty
__Floaters__Tinnitus
__Allergy
__None

EMOTION
__Anger
__Joy
__Overthinking
__Worry
__Grief
__Sadness
__Fear
__Shock

OASIS ACUPUNCTURE LLC
NEW PATIENT INTAKE FORM

Patient Name:_____Today's Date: _____

GASTROINTESTINAL

Appetite: poor / excessive / normal
any strange taste in mouth: _____
Weight: gain / loss_____lbs./in ___month
Thirst: no / excess
Drinks: like –cold / warm / hot drinks
Bowel movement: _____times/day

__Diarrhea __Constipation
__Hemorrhoid __Bloody stools
__Liver disorder __Colitis __IBS
__Gas / Bloating after meals
__Heartburn / indigestion
__None __Other_____

FEMALE only (History or current)

__Menstrual irregularity
__Discharge / spotting between cycles
__Menstrual cramping / clots
____Age Menstruation started
____Days between cycles
____Usual days of menstrual flow
Flow: __Light ___Medium ___Heavy
Color: _____

Vaginal: pain / infections / dryness
Libido: High / Low
Breast: lumps / pain / cyst
_____Date of last Pap exam
_____Date of last mammogram
_____Date of last menstruation
_____Pre-menopause / Menopause

MALE only

__Prostate concerns
__Discolored urine: what color_____
__Painful/excessive/decreased urination

____Libido: High / Low
____Impotence
____None ___Other _____

Surgery History: _____Date:_____

_____Date:_____

_____Date:_____
(List **ALL** surgeries here)

Current Medication/Supplements/Herbs: _____

_____

_____

OASIS ACUPUNCTURE LLC
NEW PATIENT INTAKE FORM

Patient Name: _____Today's Date: _____

CC: _____

What Happened: _____

Nature of pain: _____

Time of pain: _____ Daytime _____ Nighttime _____ Intermittent _____Continuous

Factor affecting pain:

Aggravated by: ____ pressure ____ warm ____cold _____ movement _____rest

____food ____ cold liquid ____hot liquid ____bowel movement

Alleviated by: ____ pressure ____ warm ____cold _____ movement _____rest

____food ____ cold liquid ____hot liquid ____bowel movement

Area of Pain/ discomfort: Severity _____localized or moving; sudden or progressive

Treatment tried_____