MODU ACUPUNCTURE

Improve Quality of your Life

Thanks for visiting our Clinic. Below are very Important questions for diagnosig condition. Please fill out the blank.

Patient Information

Name		Date		Date of Birth	
Gender	M F / Blood Type	Marital Status	Single Married	Phone#	
E-mail		Occupation		Cell#	
Address				State:	Zip:
How do you know this clinic?		Referral (Doctor):		Google:	
		Friends:		Other:	

Medical History

Medical Condition					
	☐ Hypertention	☐ Diabetes	☐ Hepatitis	☐ esophagitis	☐ Stomach Ulcer
	☐ Hyperlipidemia	☐ Gastritis	☐ Angina	☐ gout	☐ Thyroid Disease
	☐ Osteoporosis	☐ Cirrhosis	☐ Stroke	☐ arthritis	☐ Other:

Do you have any allergy or get frequent colds?	☐ Yes	☐ No
Allergy	Yes ( ) No ( ) If yes :	
Family Medical History		

Medication

Please list any medication being used:	

Complaints

Please identify your major health concerns	
Have you been given a diagnosis for these problems?	
How long have you had this problem?	

General (Please check all that apply)

☐ Poor Appetite	☐ Weakness	☐ Low Energy
☐ Hearing Loss	☐ Fevers	☐ Chills
☐ Easy to Bruise	☐ Sweat Easily	☐ Poor Balance
☐ Strong Thirst	☐ Poor Sleep	☐ Tremors
☐ Puffiness	☐ Swelling	☐ Weight Loss
☐ Night Sweats	☐ Cravings	☐ Weight Gain
☐ Poor Appetite	☐ Fatigue	☐ Other:

Head, Eyes, Ears, Nose, and Throat

☐ Dizziness	☐ Ear Ringing	☐ Night Blindness
☐ Cataracts	☐ Sore Throat	☐ lurry Vision
☐ Headaches	☐ Nose Bleeds	☐ Sinus Problems
☐ Eye Pain	☐ Ear Ringing	☐ Poor Hearing
☐ Migraines	☐ Concussions	☐ TMJ Pain
☐ Toothache	☐ Facial Pain	☐ Floaters
☐ Ear Aches	☐ Tongue Sore	☐ Other:

Skin & Hair

☐ Rashes	☐ Itching	☐ Dandruff
☐ Skin Ulcers	☐ Eczema	☐ Hair Loss
☐ Hives	☐ Pimples	☐ Recent Moles

Respiratory

☐ Cough	☐ Bronchitis	☐ Difficulty Breathing
☐ Phlegm	☐ Pneumonia	☐ Coughing Up Blood
☐ Asthma	☐ Easily Winded	☐ Painful Breathing

Cardiovascular

☐ High Blood Pressure	☐ Lightheadedness	☐ Palpitations
☐ Low Blood Pressure	☐ Phlebitis	☐ Chest Pain
☐ Cold Hands or Feet	☐ Blood Clots	☐ Fainting
☐ Swelling of Hands	☐ Swelling of Feet	

Gastro-Intestinal

☐ Nausea	☐ Constipation	☐ Chronic Laxative
☐ Bad Breath	☐ Rectal Pain	☐ Blood in Stools
☐ Indigestion	☐ Hemorrhoids	☐ Abdominal Pain
☐ Ulcers	☐ Diarrhea	☐ Belching
☐ Use	☐ Vomiting	☐ Intestinal Gas

Caution

If you are planning for a general check up, stop taking the herbal medicine at least 3 days prior to the checking date.

If you get any allergic response, stop the herbal medicine and get treatment first. It is usually ok to continue but some people can have continuous allergic response. If the symptoms does not get better, stop the herbal medicine completely. (In this cas, we will refund for the remaining herbal medicine)

If you get any abnormal vaginal bleeding, stop the herbal medicine and get treatment first. If the symptom is severe stop, the herbal medicine completely. (In this case, we will refund for the remaining herbal medicine)

Female Only			
Pregnant	Are you pregnant?	☐ Yes	☐ No
	do you have any plan for pregnancy?	☐ Yes	☐ No
	You should not get pregnant nor take pills during pregnancy.		☐ Understood
Period	No Menstruation	☐	since:
	Cycle of Menstruation	☐ 26-30 Days ☐ 41 Days	☐ 31-40 Days ☐ Every ______ Days
	Is it regular or irregular?	☐ Regular	☐ Irregular
	Any blood clots?	☐ No ☐ A lot	☐ Little
	What is the color of it?	☐ Bright Red ☐ Dark Red	☐ Brown
	How long does it last?		Days
	Do you have any discharge?	☐ No ☐ A lot	☐ Little ☐ All the time
	Do you have any abdominal cramps?	☐ Yes	☐ No
	Last date of period	/	/

Modu Acupuncture, P.C.
221 S. Middletown Road, Nanuet, NY 10954
Tel: 917-902-5995. Email: cs@moduacupuncture.com

Patient Advisory to Consult A Physician

Modu Acupuncture, P.C. is committed to your health and well-being. While Traditional Eastern Medicine has a great deal to offer as a health care system, it cannot entirely replace the services available from biomedical practitioners. Therefore, it is recommended that you consult a physician regarding any condition(s) for which you are seeking acupuncture or herbal treatment.

To comply with Article 160, Section 8211.1 (b) of New York State Education law, please read and sign the following statement:

I, ______________________________ (print name) do affirm that I have been advised by Modu Acupuncture, P.C. and their licensed acupuncturists, to consult a physician regarding the condition or conditions for which I seek acupuncture treatment.

Patient's (or Guardian's) Signature: ______________________________________ Date: ______________

HIPAA Notice of Privacy Practices

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I, ______________________________ (print name) do affirm that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I also have read and understand your Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's (or Guardian's) Signature: ______________________________________ Date: ______________

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ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na(Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, as, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME: ______________________________

PATIENT SIGNATURE ____
(Or Patient Representative) Date (Indicate relationship if signing for patient)

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Covid-19 Virus Screening

If you have been exposed to a communicable disease, you may spread the disease to staff or other patients, and clients in the office of Modu Acupuncture, P.C. Therefore, prior to each appointment, we will be asking the following question to reduce the chances of transmission. Thank you for your cooperation.

First Name:____.

Last Name:____.

Phone Number:____.

Address:____.

Date of Birht:____.

Gender: Male ( ) Female ( )

Do you or anyone you have recently been in contact with have any of the following symptoms? Check all that apply.

1. Fever? (Defined as over 99.8 F degree or above ( )
2. Cough or sore throat, congestion or runny nose? ( )
3. Shortness of breath or trouble breathing? ( )
4. Fatigue, muscle or body ache, headaches, or new loss of taste or smell? ( )
5. Nausea or Vomiting? ( )
6. None of the Above ( )

Have you or anyone you have recently been in contact with tested positive for or been diagnosed as having COVID-19 virus or any other communicable disease? Yes ( ) / No ( )

I understand that if the answer to any of the question is yes, I may be asked to reschedule my appointment to a late date. Yes ( ), I understand.

I attest that I have answered all the above questions truthfully and to the best of my knowledge, by signing on this document.

Signature: ____Date:__________________.

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Cancellation Policy

If you do not give us a 24-hour notice to cancel your appointment,
There will be a $20 (Twenty dollars) Charge.

You will be charged $40 for not showing on your appointment.

I read and agree to the cancellation policy of this office of Modu Acupuncture, P.C.

Patient's (or guardian's) Name:____.

Patient's (or guardian's) Signature:_____________________________________.

Date:____.