Today's Date: _____

PATIENT INFORMATION FORM

Please Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

First Name_____Last_____

Address_____City_____

State_____Zip Code_____

Home Phone (_____)_____Cell Phone (_____)_____

Work Phone (_____)_____

Email address_____

Male_____ Female_____ Age_____ DOB_____

Married_____Single_____Divorced_____

Name of Spouse_____

Employer_____Occupation_____

Emergency Contact_____Phone_____

Name of Physician_____Phone_____

Referred by_____

Friend_____Relative_____Insurance_____Other_____

Would you like to be on our Newsletter list? Yes_____ No_____

PATIENT INFORMED CONSENT

I, _____, hereby voluntarily consent to be

Treated by acupuncture and/or Chinese Herbs, administered by Anne Biris hereinafter referred to as "Practitioner". I understand that acupuncture is performed by the insertion of fine, pre-sterilized, disposable acupuncture needles (with or without the addition of electric current) through the skin, or the application of heat to the skin, or both, at certain points on the body, in an attempt to improve the body function and/or relieve pain.

I acknowledge that, although rare, certain side effects may result from acupuncture. These can include bruising, mild pain or discomfort, a feeling of weakness, fainting, nausea and a temporary aggravation of symptoms. These effects are unusual and of short duration.

I accept the fact that no guarantee is made concerning the use and effects of acupuncture or Chinese herbs. I understand that I may stop treatment at any time.

I further understand that the evaluation given to me is an energetic assessment of the acupuncture meridian network, and in no way purports to be, or replaces a western medical examination and diagnosis. In the course of the evaluation, there may be reference to the stat of various "organs", such as liver, spleen, kidneys, etc. which actually refers to energetic channels of the same name.

I acknowledge the fact that Anne Biris/Practitioner is not and does not profess to be western-trained medical doctor and does not use or advise on the use of medically prescribed pharmaceuticals or medical treatment, nor does Practitioner give and substances by injection.

Signature _____ Date _____

Patient or Guardian

OUR OFFICE PROTECTS YOUR HEALTH INFORMATION AND PRIVACY

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company and with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners. We will obtain your authorization before disclosing any information.

Safeguards in place at out office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

- About your financial transaction with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to our from other health care practitioners.
- From health care providers, insurance companies, worker's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you – *e.g.* your name, address, Social Security number, etc.)

We value our relationship with you, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours.

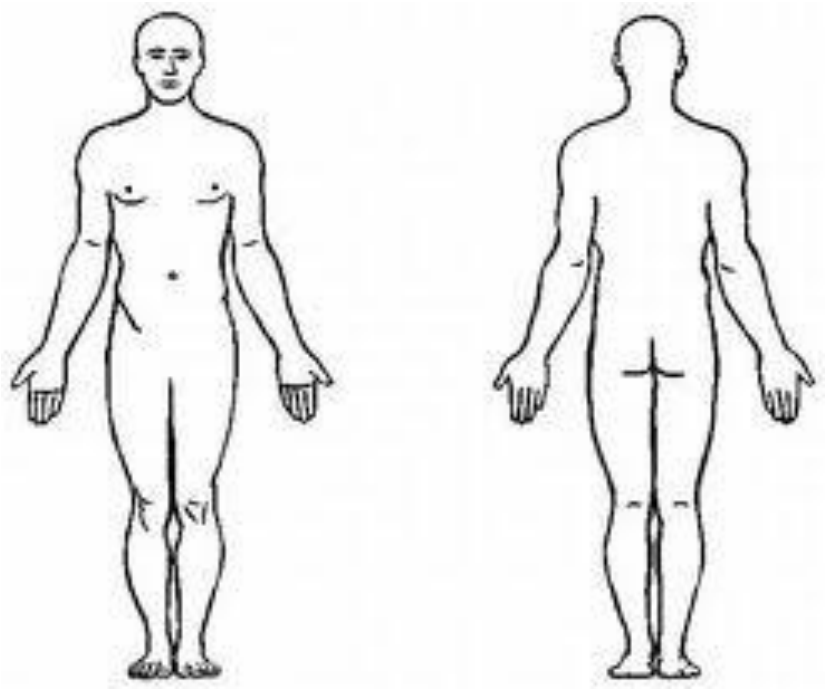
Signature _____ Date _____

Patient or guardian

I. Major Symptoms: Please list in order of importance what symptoms are of concern to you. *(most concerning to least, along with the duration of the symptom)*

1. _____
2. _____
3. _____
4. _____

Use the following illustration to indicate painful or distressed areas:



For Women:

1. Are you pregnant now? { } Yes { } No { } Unsure
2. Indicate number of occurrences:
   Live Births _____ Pregnancies _____ Miscarriages_____ Abortions _____
3. Age: First period _____ Menopause (if applicable) _____
4. Date of last Pap Smear _____ Last Mammogram _____
5. Any history of an abnormal Pap Smear? { } Yes { } No
6. Is your menses cycle regular? { } Yes { } No
   a. Average number of days of flow _____
   b. The flow is: { } Normal { } Heavy { } Light
   c. The color is: { } Normal { } Dark { } Purple { } Light Brown { } Brown
7. Do you have the following menstruation related signs/ symptoms?
   { } Difficulty with orgasm { } Cramps { } PMS
   { } Pain with Intercourse { } Nausea { } Bleeding between periods
   { } Blood clots { } Breast Distention
   { } Vaginal discharge { } Heavy Vaginal discharge between periods

For Men:

1. Do you have any bothersome urinary symptoms? { } Yes { } No

Describe: _____

2. Check all that apply:
   - { } Erectile dysfunction
   - { } Pain or swelling of the testicles
   - { } Impotence/erectile dysfunction
   - { } Feeling of coldness or numbness in genitalia
   - { } Pain/subtly of testicles
   - { } Difficulty with orgasm
   - { } Frequent urination
   - { } Premature ejaculation

3. Do you get up at night to urinate? { } Yes { } No How often? _____
4. To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)? _____
5. Have you sought Medical intervention for these problems? If so, when?
   _____
6. What treatments have you tried for these problems and how successful have they been?
   _____

II. Medical History

Please check all that apply *Date Diagnosed*

Diabetes	
High Blood Pressure	
Low Blood Pressure	
Thyroid disease	
Cancer	
HIV	
High Cholesterol	
Seizures	
Hepatitis	
Other	

III. Surgical History

_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

IV. Family History

Please check all that apply and state how you are related to the family member with that condition.

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Heart disease					
Cancer					
Hypertension					
Stroke					
Asthma					
Allergies					
Migraines					
Depression					
Other mental illness					
Substance abuse					
Osteoporosis					
Diabetes					
Glaucoma					

V. Medications / Supplements

Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies (to medications, chemicals or foods):

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

VI. Nutrition

1. Do you follow a special diet? { } Yes { } No
   If yes, describe the diet? (ie Vegetarian, vegan, low carb, etc.)
   _____
2. What do you eat on a "typical" day? _____
   a. Breakfast:_____
   b. Lunch: _____
   c. Dinner: _____
   d. Snacks: _____
   e. Foods you tend to crave: _____
   f. Foods you dislike: _____

VII. Social History

1. How much per day do you use the following?
   a. Coffee, tea, soft drinks:_____
   b. Alcohol: _____
   c. Cigarettes, cigars, other tobacco:_____
   d. Other drugs: _____
2. Have you ever had a problem with alcohol or alcoholism? { } Yes { } No
3. Have you ever had a problem with dependency on drugs? { } Yes { } No
4. If yes, which and when? _____
5. In the past year, how many days have been significantly affected by your health? _____
6. How many times were you in the hospital? _____
7. Please describe your current exercise regimen: Hours per week: _____
   Activities: _____
8. How many hours of sleep do you usually get per night during the week? _____
9. Do you awake feeling rested? { } Yes { } No
10. Who would you describe as your source of primary social support? (relationship to you)
    _____

VIII. Other Information

Please list and briefly describe the most significant events in your life:

1. _____
2. _____
3. _____

Have you been treated for emotional issues? { } Yes { } No
Have you ever considered or attempted suicide? { } Yes { } No
Do you have any other neurological or psychological problems? { } Yes { } No
Please provide us with any other information that you think is relevant for us to know:

_____
_____
_____
_____

HEALTH: CHECK ALL THAT APPLY

Condition	*Past*	*Current*	*Condition*	*Past*	*Current*	*Condition*	*Past*	*Current*
GENERAL			**NOSE/THROAT/MOUTH**			**GENITO-URINARY**		
Poor appetite			Nose bleeds			Kidney stones		
Excessive appetite			Sinus infections			Pain		
Insomnia			Hay fever/allergies			Frequent urination		
Fatigue			Recurring sore throat			Blood in urine		
Fevers			Grinding teeth			Urgency to urinate		
Night Sweats			Difficulty swallowing			Unable to hold urine		
Sweat easily			**CARDIOVASCULAR**			**MALE**		
Chills			High blood pressure			Pain/itching genitalia		
Localized weakness			Low blood pressure			Genital lesions/discharge		
Poor coordination			Blood clots			Impotence		
Bleed/ bruise easily			Palpitations			Weak urinary stream		
Catch cold easily			Phlebitis			Lumps in testicles		
Change in appetite			Chest pain			Other:		
Strong thirst			Irregular heart beat			**FEMALE**		
Other:			Cold hands/feet			Urinary tract infection		
SKIN & HAIR			Fainting			Frequent vaginal infections		
Rashes			Difficult breathing			Pain/itching of genitalia		
Hives			Swelling of hands/feet			Genital lesions/discharge		
Itching			Other:			Pelvic inflammatory disease		
Eczema			**RESPIRATORY**			**NEUROLOGICAL**		
Pimples			Asthma			Seizures		
Dryness			Bronchitis			Tremors		
Tumors, lumps			Frequent colds			Numbness/tingling of limbs		
HEAD & NECK			Chronic Obstructive			Concussion		
Dizziness			Pulmonary disease			Pain		
Fainting			Pneumonia			Paralysis		
Neck stiffness			Cough			Other:		
Enlarged lymph glands			Coughing blood			**MUSCULAR / SKELETAL**		
Headaches			Production of phlegm			Stiff neck		
Concussions			Other:			Low back pain		
Other:			**GASTRO-INTESTINAL**			Back pain		
EARS			Nausea			Muscle spasm		
Infection			Vomiting			Twitching/cramps		
Ringing			Diarrhea			Sore, cold or weak knees		
Decreased hearing			Belching			Joint pain		
Other:			Blood in stool/black			**PSYCHOLOGICAL**		
EYES			Bad breath			Depression		
Blurred vision			Rectal pain			Anxiety/stress		
Visual changes			Hemorrhoids			Irritability		
Poor night vision			Constipation			Emotional problems		
Spots			Pain or cramps			Psychological problems		
Cataracts			Indigestion			Other:		
Glasses/contacts			Gall bladder disorder			**INFECTION SCREENING**		
Eye inflammation			Gas			HIV		
Other:			Other:			TB		
						Hepatitis		
						Gonorrhea		
						Chlamydia		
						Syphilis		
						Genital warts		
						Herpes: oral		
						Herpes: genital		