

Sean Rachlin, L.Ac., LMT

Patient Record

Please complete the entire form so that your claim can be submitted for payment to the insurance company on your behalf.

1.

First Name _____ Last Name _____

Date of Birth _____ SS# _____ - _____ - _____

Address: _____

Home Phone #: _____ Work / Mobile Phone#: _____

Employer's Name or School Name: _____

Is your condition due to an: Accident _____ Job Injury: _____ Other: _____

2.

Insurance Company: _____ Insurance ID# _____

Insurance Group# _____ Insurance Telephone# _____

Insurance Address: _____

I authorize payment of insurance benefits otherwise payable to me to be paid directly to the practitioner. I agree to pay for treatment sessions, co-payments, deductibles, and coinsurances for the services performed in the event that my health insurance policy does not cover those services or as required by my policy. I authorize release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

Patient Signature or Legal Representative

Date:

*****If the patient is insured through the spouse or parent, please complete section 3*****

3.

Patient's relation to the insured (circle one please) a)Spouse b)Parent

First Name: _____ Last Name: _____
Spouse/Parent Spouse/Parent

Date of Birth: _____ SS# _____ - _____ - _____
Spouse/Parent Spouse/Parent

Employer's Name or School Name _____
Spouse/Parent

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Personal Information

This record will be used to aid us in providing the best treatment possible for you. It will be kept strictly **CONFIDENTIAL**. Please read carefully and print or write legibly.

First Name _____ Last Name _____

Home Phone _____ Work/Mobile Phone _____ Email _____

Date of Birth _____ Age _____ Sex: M / F Height _____ Weight _____

Marital Status: Married / Single / Divorced / Widowed # of children _____ Occupation: _____

Primary Care Physician: _____ Specialty: _____ Phone #: _____

Emergency Contact Person: _____ Phone Number: _____

Have you received Acupuncture before? yes / no If yes, with whom? _____

Who should we thank for referring you to this office? _____

What are the main health problems/concerns for which you are seeking treatment? _____

What other forms of treatment have you sought? _____

List any other health problems you currently have. _____

Allergies, food sensitivities or food cravings? _____

Surgeries / Hospitalizations (include dates) _____

Please list current medications and reason for taking them. (Include vitamins, drugs, herbs, etc)

Lab results (include copies) _____

Date of Last Check-up _____

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Family Medical History: Diabetes Cancer Asthma High Blood Pressure
(Mom, Dad, Siblings, Grandparents)
 Seizures Stroke Heart Disease Emotional Disorders
 Tuberculosis Hepatitis Rheumatic Fever Infectious Disease

Do any of the above apply to you? If yes, please list _____

Occupational Stress (chemical, physical, psychological): Please Describe: _____

Do you have a regular exercise program? Yes / No Please Describe: _____

Have you ever been on a restricted diet? Yes / No Please Describe: _____

Please indicate the use and frequency of the following:

Coffee / Black tea _____ Tobacco _____

Alcohol _____ Soda _____

Water _____ Non-medical drugs _____

How do you feel about the following areas of your life? (family, diet, sex life, self, work, exercise, spirituality)

Comments:

Please Answer the Following Questions

- | | | |
|-------------------------------------|-----|----|
| 1. Do you have a tendency to faint? | Yes | No |
| 2. Do you have a pacemaker? | Yes | No |
| 3. Do you bleed for a long time? | Yes | No |
| 4. Have you ever had Hepatitis | Yes | No |
| 5. Do you have HIV or AIDS? | Yes | No |
| 6. Are you hungry now? | Yes | No |
| 7. Are you tired? | Yes | No |
| 8. Are you pregnant? | Yes | No |

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The following is a list of symptoms which you may or may not have experienced. Please indicate as follows:

No mark () = Never experience (>) = Sometimes Experience (+) = Frequently Experience

Cardiovascular: ___ Shortness of Breath ___ High Blood Pressure ___ Irregular Heart Beat ___ Heart Palpitation
___ Dizziness ___ Chest Pain or Pressure ___ Leg Cramps

Respiratory: ___ Cough ___ Cough up Blood ___ Sore Throats ___ Nasal Problems ___ Nose Bleed
___ Pneumonia ___ Hay fever ___ Bronchitis

Gastrointestinal: ___ Indigestion ___ Abdominal Pain or Cramps ___ Gall Stones ___ Heartburn
___ Belching or Burping ___ Nausea and Vomiting ___ Excess Appetite ___ Decreased Appetite
___ Excess Thirst ___ Constipation ___ Diarrhea ___ Bloody or Black Bowel Movement ___ Colitis/Diverticulitis

Skin: ___ Ulcerations ___ Rash ___ Eczema ___ Edema ___ Acne ___ Itchy ___ Dry ___ Greasy

Genitourinary: ___ Frequent Urination ___ Painful Urination ___ Retention of Urine ___ Incontinence
___ Kidney Stones ___ Bloody Discharge ___ Genital Pain ___ Decreased Sex Drive ___ Venereal Disease

Men Only: ___ Prostate Problems ___ Testicular Pain ___ Impotence ___ Premature Ejaculation

Women Only: ___ Pre-menstrual pain ___ Menstrual Pain ___ Irregular Menstrual Cycle ___ Hot Flashes
___ Swelling/Pain of Breasts

Musculoskeletal: ___ Back Pain ___ Arthritis ___ Muscle Pain or Cramps ___ Muscle Spasms ___ Joint Pain

Miscellaneous: ___ Eye Problems ___ See Spots or Floaters ___ Blurry Vision ___ Memory Loss
___ Hearing Loss ___ Ringing in Ears ___ Headaches ___ Insomnia ___ Nightmares ___ Mental Restlessness
___ Easily Angered or Agitated ___ Fatigue ___ Fever ___ Chills ___ Night Sweats ___ Intolerance to Cold
___ Intolerance to Heat ___ Cold Hands and/or Feet ___ Soft or Brittle Nails ___ Jaundice

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Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or other Chinese Medicine procedures by Sean Rachlin, L.Ac., LMT. I understand that in addition to treatment by Sean Rachlin, L.Ac., LMT, care by a licensed physician is important and is strongly recommended.

Acupuncture, Moxibustion: I understand that acupuncture is performed by the insertion of pre-sterilized, one time use, surgical stainless steel needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Acupressure, Massage Therapy, Cupping, Gua-Sha: I understand that I may also be given Acupressure, Massage Therapy, Cupping or Gua-Sha as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment or stop the treatment if it is too uncomfortable.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and inform Sean Rachlin, L.Ac., LMT as soon as possible.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

HIPPA Privacy Act: Ensures that all of your personal and health information remains confidential at all times between this office, your insurance company and you. Should you have any questions about the privacy of your information at this office, you may ask Sean Rachlin, L.Ac., LMT at any time.

I have carefully read and understand all of the above information and I am fully aware of what I am signing. I understand that I may ask Sean Rachlin, L.Ac., LMT for a more detailed explanation of the procedures or treatment, other alternative procedures or methods of treatment and information about the material risks of the procedures or treatment. I give my permission and consent to treatment.

Signature of Patient or Legal Representative: _____

Date: _____