The Golden Needle Wellness

Ching Liu, MTOM, LMT

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Dear New Patient,

Welcome! Thank you for your interest in Chinese medicine. Your decision to entrust the care of your health to me is a great honor, and I am truly grateful for that honor. I want you to know that I will always endeavor to provide you with the highest quality care. I also want you to know that my goal as your health care practitioner is not to heal you. My goal is to empower you to heal yourself.

True health is not just about making a problem go away, but is, instead about removing the possibility of the problem ever occurring again. This requires working with you as a whole person, not just the parts that aren't working properly. It is a much greater challenge, but it also reaps much greater rewards. To this end, I have sent you some forms that I'd like you to fill out and bring with you to your first appointment. I assure you that all information you provide on these forms will be kept strictly confidential, and will never be shared without your explicit written permission. If you have any questions, please feel free to call me at (207) 808-0548, and I will be happy to answer them.

Again, welcome to my clinic. You have taken an important step on your journey to vibrant health. It is my privilege to walk alongside you.

Be well,

Ching Liu, MTOM, LMT

Our Clinic Protects Your Health Information and Privacy

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 other medical practitioners that you authorize.

Safeguards in place at our 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:

In administering your health care, we gather and maintain information that may include non-public personal information.:

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

You will 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.).

I value our relationship, and respect your right to privacy. If you have questions about these privacy guidelines, please call during regular business hours at (207)808-0548.

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

NAME _____ BIRTHDATE _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

X_____ _____ _____

Patient Signature or Legal Representative **Date** **Printed Name and Relationship**

Office Use Only:

Î Accepted _____ _____

Î Denied Signature Date

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PATIENT CONFIDENTIAL INFORMATION

1. Name _____
First Middle Last Preferred name

2. Address _____
Street City State Zip

3. Home Phone _____ 4. Work Phone _____

5. Mobile _____ 6. Preferred Daytime Phone Home Work Mobile

7. Fax _____ 8. Email _____

9. Date of Birth _____ 10. Age _____ 11. Gender M F 12. Marital: M S D W

15. Occupation _____ 16. Employer _____

17. Work Address _____
Street City St ate Zip

20. In case of emergency, call _____ Relationship _____

Address _____ Phone _____
Street City State Zip

21. FOR MINORS Please list both parents' names and addresses:

_____

_____

_____ I understand that the practitioner has a 24-hour cancellation policy. This means that if I cancel an appointment less than 24 hours before the scheduled time, I will be charged the standard fee.
Initials

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of my health.

DATED _____ PATIENT'S SIGNATURE _____
(parent's signature if patient is minor)

How did you hear about me? _____

Patient Health History

Name: _____ _____ M F _____
First Last Preferred Age Gender Date

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Note: Please do not treat this questionnaire as a chore to be completed. Instead, treat it as an opportunity to become aware of the current state of your overall health. This awareness is a crucial first step to self-healing. If you find it overwhelming, do not hesitate to take a break and come back to it when you feel ready.

1. When and where did you last receive health care? _____

For what reason? _____

2. Has your case been referred to an attorney? Y N

3. What is your **main objective** in coming here, and what are the underlying health conditions that motivate this objective?
   - Please phrase your objective in the form of an active statement that describes what you want, not what you don't want. E.g. if you have back pain, then you could say, "I have come in order to have a strong, flexible, healthy back," but you would not say, "I have come to have a pain-free back", or "I have come to get rid of my back pain."
   - When describing your underlying health conditions, please include how the conditions affect you, what you have done to correct them, and when they started.

   Main objective: _____
   Underlying health conditions: _____
   _____
   _____

4. Do you have any **secondary objectives** in coming here?
   a. Objective: _____
      Underlying health conditions: _____
      _____
   b. Objective: _____
      Underlying health conditions: _____
      _____
   c. Objective: _____
      Underlying health conditions: _____
      _____
   d. Objective: _____
      Underlying health conditions: _____
      _____

5. Please list any foods, drugs, or medications you are **hypersensitive or allergic** to (please include reaction):

_____

_____

6. Please list any **medications** (prescribed and over-the-counter), **vitamins, supplements, and herbs** you are currently taking:

_____

_____

_____

7. Do you have any reason to believe you may be **pregnant**? Y N

If so, how far along are you? _____

8. Do you have any **infectious diseases**? Y N If yes, please identify: _____

9. **Height**: _____ **Weight**: Currently: _____ Past Maximum: _____ When? _____

10. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

11. **Family history:**

	Self	Father	Mother	Brothers	Sisters	Spouse	Children
Age, or age at death	_____	_____	_____	_____	_____	_____	_____
If deceased, cause of death:	_____	_____	_____	_____	_____	_____	_____
If living, health status:	_____	_____	_____	_____	_____	_____	_____
Check if applicable:	(10 = Vibrant health, 5 = Average health, 1 = Very poor health)						
Cancer	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Hay fever/Hives	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐

12. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: _____

13. **Hospitalizations and Surgeries:**
Date: Reason: Operation(s) performed:

14. Please describe your **birth**:

15. Please describe your **childhood**:

16. Please list any **serious and/or childhood illnesses** and their approximate dates:
Date: Illness:

17. Please describe any **traumatic experiences** you have had and give their approximate dates (i.e. divorce, change of residence, bankruptcy, injury, death of a loved one, etc.)
Date: Event:

For the following questions, Please *circle* any of the following that you experience *now* and *underline* any that you have experienced in the *past*. Then write a number next to the condition representing how severe it was or is for you. 10 means extremely severe, 1 means very mild. If you don't know what the condition is, just write a question mark.

- For example, if you have experienced mild ear ringing in the past, and currently experience severe sinus problems, you would do the following:

Ear ringing 3 (sinus problems) 8

18. **Emotions**:

Mood Swings | Anxiety | Mental Tension | Depression | Mania

Please list one or two emotions that are influential in your life and which are either frequently experienced or difficult to express:

_____

19. **Energy and Immunity**:

Fatigue | Slow Wound Healing | Chronic Infections | Chronic Fatigue Syndrome

20. **Head, Eye, Ear, Nose, and Throat**:

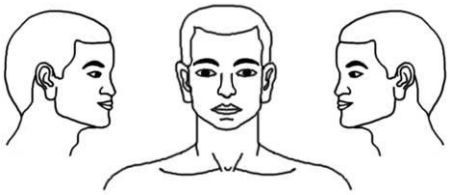
Impaired Vision | Eye Pain/Strain | Headaches: please describe, and mark where you feel pain: _____

Glasses/Contacts | Tearing/Dryness | Glaucoma

Impaired Hearing | Ear Ringing | Earaches

Nose Bleeds | Hay Fever | Sinus Problems

Frequent Sore Throats | Teeth Grinding | TMJ/Jaw Problems



21. **Respiratory**:

Pneumonia | Frequent Colds | Difficulty Breathing | Emphysema

Persistent Cough | Pleurisy | Asthma | Tuberculosis | Shortness of Breath

Other Respiratory Problems: _____

22. **Cardiovascular**:

Heart Disease | Chest Pain | Swelling of Ankles | High Blood Pressure | Palpitations/Fluttering

Stroke | Heart Murmurs | Rheumatic Fever | Varicose Veins

23. **Gastrointestinal**:

Ulcers | Changes in Appetite | Nausea/Vomiting | Heartburn | Abdominal Pain

Passing Gas | Belching | Gall Bladder Disease | Liver Disease | Hemorrhoids

24. **Genito-Urinary Tract**:

Kidney Disease | Painful Urination | Frequent UTI | Frequent Urination | Frequent Urination at Night

Kidney Stones | Impaired Urination | Blood in Urine

25. **Female Reproductive/Breasts**:

Breast Lumps/Tenderness | Nipple Discharge | Vaginal Discharge | Difficulty Conceiving | Menopausal Symptoms

26. **Menstrual/Birthing History**:

# of Pregnancies: _____ # of Live Births: _____ # of Miscarriages: _____

Age of First Menses: _____ # of Abortions: _____ Birth Control Type: _____

Date of last period: _____

Length of Cycle: _____ days If irregular, give range: _____ to _____ days

Duration of bleeding: _____ days Bleeding between cycles? Y N When? _____

Color of blood: ☐ pale red ☐ bright red ☐ dark red ☐ brown ☐ purple

Consistency of blood: ☐ watery ☐ normal ☐ thick, sticky ☐ clots

Quantity of blood: ☐ very light ☐ light ☐ normal ☐ heavy ☐ very heavy

PMS: ☐ breast distention ☐ headache ☐ bloating, edema ☐ chocolate craving

☐ emotional What emotions? _____

☐ other

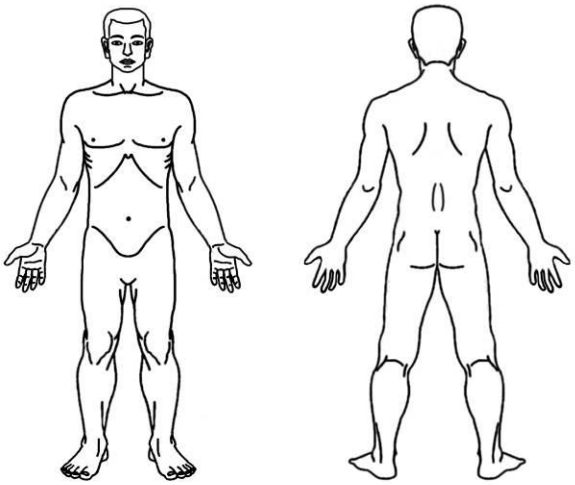
Please describe any cramping: _____

27. **Male Reproductive**:

Sexual Difficulties | Prostrate Problems | Testicular Pain/Swelling | Penile Discharge

28. **Musculoskeletal**:

Please mark where you feel pain with a number, and describe the pain on the corresponding lines:



1. _____

2. _____

3. _____

4. _____

29. **Neurological**:

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

30. **Endocrine**:

Hypothyroid Hyperthyroid Hypoglycemia Feeling Hot or Cold Night Sweats

Diabetes Type 1 Diabetes Type 2

31. **Other**:

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else I should know? _____

_____

32. **Lifestyle**:

a. Do you now, or have you ever undertaken a restricted diet? Please give dates and describe:

_____

_____

b. Please describe a typical day's diet. This includes all meals, snacks, and beverages.

_____

_____

c. Times of the day you usually eat: _____

_____

d. Typical state of mind as you eat: _____

e. Cups of water you drink each day: _____

f. Exercise routine: _____

_____

g. Spiritual practice: _____

_____

h. Typical bedtime: _____ Do you sleep soundly? Y N

i. Typical wake time: _____ Do you wake rested? Y N

j. Level of education completed: High School Bachelors Masters Doctorate Other _____

k. Do you have any silver amalgam fillings in your mouth? Y N

l. Current occupation: _____ Hours worked/week: _____

m. Do you enjoy this occupation? Why/why not? _____

_____

n. Briefly describe your occupational history:
Date: Occupation:

_____ _____

_____ _____

_____ _____

_____

o. Nicotine/Alcohol/Caffeine/Recreational Drug Use: _____

_____

p. What do you like to do in your free time? _____

_____

_____

_____

For the following section, please ✓ check once for mild conditions, ✓✓ check twice for moderate conditions, and check ✓✓✓ three times for serious conditions. Some conditions appear more than once – just repeat your answer anywhere they appear.

Water	Wood	Fire
☐☐☐ Lower back pain	☐☐☐ Headaches	☐☐☐ Sores on tongue
☐☐☐ Knee pain	☐☐☐ Migraines	☐☐☐ Sore throat/tonsillitis
☐☐☐ Leg weakness	☐☐☐ Fullness/pain below ribs	☐☐☐ Dry scalp
☐☐☐ Neck pain	☐☐☐ Wrist & hand pain/soreness	☐☐☐ Skin eruptions/rashes
☐☐☐ Cold arms and/or legs	☐☐☐ Shoulder/neck tension	☐☐☐ Itching/burning skin
☐☐☐ Hearing loss	☐☐☐ Convulsions/spasms	☐☐☐ Cysts/tumors
☐☐☐ Ringing in ears	☐☐☐ Cold fingers/toes	☐☐☐ Ear infections
☐☐☐ Dizziness	☐☐☐ Ringing in ears	☐☐☐ Lymphatic swelling
☐☐☐ Sinus congestion	☐☐☐ Poor eyesight	☐☐☐ Hot hands/feet
☐☐☐ Edema (water retention)	☐☐☐ Dry/red eyes	☐☐☐ Dislike of heat
☐☐☐ Darkness under eyes	☐☐☐ Watery eyes	☐☐☐ Dry mouth
☐☐☐ Dislike of cold	☐☐☐ Eye infections	☐☐☐ Gum problems
☐☐☐ Hair thinning or loss	☐☐☐ Blurry vision	☐☐☐ Nose bleeds
☐☐☐ Premature aging	☐☐☐ Poor night vision	☐☐☐ Facial redness
☐☐☐ Frequent urination	☐☐☐ Eczema	☐☐☐ Heart palpitations
☐☐☐ Kidney stones	☐☐☐ Shingles	☐☐☐ Chest pain
☐☐☐ Perspire very easily	☐☐☐ Herpes	☐☐☐ Dark urine
☐☐☐ Night sweats	☐☐☐ Warts	☐☐☐ Night sweats
☐☐☐ Hot sensation in afternoon	☐☐☐ Constipation	☐☐☐ Difficulty falling asleep
☐☐☐ Asthma, difficult to inhale	☐☐☐ Alternating constipation/diarrhea	☐☐☐ Waking very easily/often
☐☐☐ Rapid weight change	☐☐☐ Hepatitis	☐☐☐ Vivid dreaming
☐☐☐ Loose teeth	☐☐☐ Stomach ulcers	☐☐☐ Fatigue on waking
☐☐☐ Reduced sexual energy	☐☐☐ Vomiting	☐☐☐ Thirsty but don't like to drink
☐☐☐ Increased sexual energy	☐☐☐ Gallstones	☐☐☐ Thirst for cold drinks
☐☐☐ Thyroid problems	☐☐☐ Insomnia 11P to 3A	☐☐☐ Frequent/extreme thirst
☐☐☐ Diabetes	☐☐☐ Craving for sour taste	☐☐☐ Craving for bitter taste
☐☐☐ Poor memory/concentration	☐☐☐ PMS/painful menses	☐☐☐ Laughing to cover up other emotions
☐☐☐ Fatigue	☐☐☐ Bitter taste in mouth	☐☐☐ "Adrenaline junkie"
☐☐☐ Thirst for hot drinks	☐☐☐ Irritability	☐☐☐ Restlessness
☐☐☐ Craving for salty taste	☐☐☐ Indecisiveness	☐☐☐ Anxiety
☐☐☐ Emotional instability	☐☐☐ Frustration	☐☐☐ Manic behavior
☐☐☐ Often feel afraid	☐☐☐ Depression	
	☐☐☐ Nervousness	
	☐☐☐ Easily angered	

Earth	Metal
☐☐☐ Heaviness in legs	☐☐☐ Bronchitis
☐☐☐ Indigestion	☐☐☐ Asthma, difficult to exhale
☐☐☐ Flatulence	☐☐☐ Shallow breathing
☐☐☐ Food allergies	☐☐☐ Cough
☐☐☐ Loose stools	☐☐☐ Sinus congestion
☐☐☐ Increased appetite	☐☐☐ Nasal infections
☐☐☐ Decreased appetite	☐☐☐ Dry skin
☐☐☐ Hungry but don't want to eat	☐☐☐ Catch colds easily/often
☐☐☐ Nausea	☐☐☐ Sweating with mild movement
☐☐☐ Vomiting	☐☐☐ Constipation
☐☐☐ Abdominal bloating	☐☐☐ Craving for spicy taste
☐☐☐ Stomach pain/ulcer	☐☐☐ Feelings of grief/sadness
☐☐☐ Sores on lips/in mouth	☐☐☐ Uncontrollable weeping
☐☐☐ Heartburn	☐☐☐ Lack of inspiration in life
☐☐☐ Bad breath	
☐☐☐ Fatigue	
☐☐☐ Low body weight	
☐☐☐ Anemia	
☐☐☐ Prolonged bleeding (when injured)	
☐☐☐ Easy bruising	
☐☐☐ Organ prolapse	
☐☐☐ Hemorrhoids	
☐☐☐ Vaginal infections	
☐☐☐ Sticky saliva	
☐☐☐ Thirsty but don't like to drink	
☐☐☐ Craving for sweet taste	
☐☐☐ Not feeling supported/nurtured	
☐☐☐ Putting others' needs over your own	