

David A. Tucker, L.Ac, L.M.P.

4425 Fremont Avenue North

Seattle, WA 98103

-PATIENT CONFIDENTIAL INFORMATION

1. Name _____
 First Middle Last

2. Address _____
 Street City State Zip

3. Home Phone: _____ 4. Business Phone: _____
 Cell Phone: _____ Extension: _____

5. Fax Number: _____ 6. Email: _____

7. Age _____ 8. Date of Birth _____ 9. Sex _____ 10. Marital: M S D W

11. Social Security No _____ 12. Driver's License No _____

13. Occupation _____ 14. Employer _____

Employer's Address _____
 Street City State Zip

BRIEF CASE HISTORY

16. Chief Complaint _____

17. Complaint result of: Auto Accident Injury Job Related Other

18. Date of accident/Injury/Other _____ / _____ / _____

19. Have you seen any other doctor about this condition? _____ If yes, when? _____

21. Spouse's name _____ Occupation _____
 Employer _____ Address _____ Phone _____

22. Nearest relative not living with you _____
 Address _____
 Street City State Zip Phone _____

23. In case of emergency, call _____
 Name Street City Phone

FOR FEMALES: Are you pregnant? _____ IF YES, HOW LONG? _____

FOR MINORS: List both parents' names and addresses

FINANCIAL ARRANGEMENTS

How do you plan to handle your account? (Check one) Cash Check Credit Card

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 this complaint.

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

David A. Tucker, L.Ac, L.M.P.

4425 Fremont Avenue North
Seattle, WA 98103

Referred by

The Zen of Healing
David A. Tucker, L.Ac., L.M.P. - Informed Consent
4425 Fremont Avenue North
Seattle, WA 98103

I, the undersigned, hereby authorize David A. Tucker to perform the following procedures:

- **Acupuncture:** The insertion of pre-sterilized, disposable needles through the skin into the underlying tissues at specific points on the surface of the body.
- **Moxibustion:** The direct or indirect warming of specific points using the herb mugwort (*artemesia vulgaris*)
- **Chinese Herbs:** Recommendation of patent, granular, and/or loose herbs from the Chinese Materia Medica
- **Electroacupuncture:** Using very small amounts of electricity to stimulate specific acupuncture points.
- **Infrared Heat:** Applying heat generated by an infrared lamp over a specific area of the body.
- **Cupping:** Glass cups are placed on the skin with a vacuum created by heat or suction device.
- **Acupressure:** Traditional Chinese medical massage and manual therapy.
- **Liniments, Oils, Plasters:** Herbal formulas applied topically to the skin.
- **Dietary Advice:** Suggestions for nutrition and herbal food products.

I recognize the potential benefits and risks of these procedures, including but not limited to:

Potential Benefits: Drugless relief of presenting symptoms and improved balance of body energies that may lead to the prevention, improvement or elimination of the presenting problem.

Potential Risks: Discomfort, pain, bruising, burning, bleeding, infection at the site of the procedure, temporary discoloration of the skin, possible aggravation of symptoms existing prior to the acupuncture treatment.

Patients with bleeding disorders or pacemakers as well as pregnant patients should inform the practitioner prior to receiving treatment.

Financial Terms - Payment is expected following treatment. Treatment fees are as follows unless otherwise arranged: Acupuncture - \$170 for the first visit and then \$90 thereafter, Massage - \$90 for an hour and \$125 for an hour and a half, Extended Appointment - acupuncture followed by 20-25 minutes of massage/acutonics/qi gong/meditation - \$125. The treatment fees do not include the cost of herbs or supplements. Please make your payment in full using either check or cash after the treatment. If you are unable to keep an appointment, please notify me at least 24 hours before the scheduled date or it will be necessary to pay the full appointment fee.

With this knowledge, I voluntarily consent to the above procedures and financial terms, realizing that no guarantees have been given to me by David A. Tucker regarding cure or improvement of my condition. I hereby release David A. Tucker from any and all liability which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

Signature of patient (or guardian if under 18)

Date

David A. Tucker received his Master's Degree in Acupuncture and Oriental Medicine from Bastyr University in 2005. He has passed the National Board Examination for Oriental Medicine administered by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) and is designated a Diplomate of Oriental Medicine. He is a Licensed Acupuncturist in the State of Washington, holding Acupuncture License number AC2826, active from 2005. David received his massage training from the Brenneke School of Massage and has passed the National Certification Exam through the National Certification Board for Therapeutic Massage and Bodywork (NCBTMB). He is a Licensed Massage Practitioner in the State of Washington, holding Massage License number MA19464, active from 2003.

David A. Tucker, L.Ac, LMP

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Seattle, WA 98103

Notice of Patient Privacy Policy

Dear Valued Patient,

This notice describes this 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 this office, I may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- 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, I 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, workman's comp and your employer, and other third part administrators (e.g. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information that has 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 425-466-3037.

Yours truly,

David A. Tucker, L.Ac., L.M.P.
4425 Fremont Avenue North
Seattle, WA 98103

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Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by David A. Tucker, L.Ac., L.M.P. for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by David A. Tucker, L.Ac., L.M.P. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. David A. Tucker, L.Ac., L.M.P. is not required to agree to the restrictions that I may request. However, if he agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time except to the extent that David A. Tucker, L.Ac., L.M.P. has taken action in reliance on this consent.

My identifiable health information means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review David A. Tucker, L.Ac., L.M.P. Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations under David A. Tucker, L.Ac., L.M.P. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and David A. Tucker, L.Ac., L.M.P. with respect to my identifiable health information.

David A. Tucker, L.Ac., L.M.P. reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

Signature of Patient or Authorized Representative

Date

Printed Name and Relationship



David A. Tucker, MSAOM, L.Ac., L.M.P.
Patient Health History

Name: _____
(first) (middle) (last)

Date: ____/____/____

Date of Birth: ____/____/____ Age: _____ Gender: M/F Marital status: S M D W

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

1. When and where did you last receive health care? For what reason?

2. Please identify the health concerns that have brought you here, in order of importance below:

Condition

Past Treatment

a. _____

b. _____

c. _____

d. _____

3. Please list other clinicians or practitioners you are currently under the care of:

Name

Modality (i.e. MD, ND, Chiropractor, Counselor, etc.)

Contact

a. _____

b. _____

c. _____

d. _____

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

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

Name	Dose/Frequency	Reason	Name	Dose/Frequency	Reason
------	----------------	--------	------	----------------	--------

6. Family History:	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Children</u>
<u>Check those applicable:</u>						
Age (if living)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

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

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

9. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

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

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

Others: _____

11. **History of Traumas:** _____

12. **Hospitalizations and Surgeries:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

13. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. Do you have any reason to believe that you are pregnant? Y N If so, how far along are you? _____

Review of Body Systems

<p>15. Skin (check all that apply)</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:70%;"></th> <th style="width:10%; text-align: center;">Current</th> <th style="width:10%; text-align: center;">Past</th> <th style="width:10%; text-align: center;"><i>Notes (office use)</i></th> </tr> </thead> <tbody> <tr><td>Acne</td><td></td><td></td><td rowspan="14" style="background-color: #e0e0e0;"></td></tr> <tr><td>Bruising</td><td></td><td></td></tr> <tr><td>Eczema</td><td></td><td></td></tr> <tr><td>Itching/Dryness</td><td></td><td></td></tr> <tr><td>Hives</td><td></td><td></td></tr> <tr><td>Jaundice</td><td></td><td></td></tr> <tr><td>Psoriasis</td><td></td><td></td></tr> <tr><td>Rashes</td><td></td><td></td></tr> <tr><td>Skin Changes</td><td></td><td></td></tr> <tr><td>Excessive Sweating</td><td></td><td></td></tr> <tr><td>Night Sweating</td><td></td><td></td></tr> <tr><td>Hair/Nail Changes</td><td></td><td></td></tr> </tbody> </table>		Current	Past	<i>Notes (office use)</i>	Acne				Bruising			Eczema			Itching/Dryness			Hives			Jaundice			Psoriasis			Rashes			Skin Changes			Excessive Sweating			Night Sweating			Hair/Nail Changes			<p>18. Musculoskeletal (check all that apply)</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:70%;"></th> <th style="width:10%; text-align: center;">Current</th> <th style="width:10%; text-align: center;">Past</th> <th style="width:10%; text-align: center;"><i>Notes (office use)</i></th> </tr> </thead> <tbody> <tr><td>Arm or Hand Pain</td><td></td><td></td><td rowspan="10" style="background-color: #e0e0e0;"></td></tr> <tr><td>Arthritis - Rheumatoid</td><td></td><td></td></tr> <tr><td>Arthritis - Osteo</td><td></td><td></td></tr> <tr><td>Back Pain (circle below) Upper Middle Lower</td><td></td><td></td></tr> <tr><td>Joint Pain Where?</td><td></td><td></td></tr> <tr><td>Leg or Foot Pain</td><td></td><td></td></tr> <tr><td>Muscle Spasm/Cramp</td><td></td><td></td></tr> <tr><td>Neck/Shoulder Pain</td><td></td><td></td></tr> </tbody> </table>		Current	Past	<i>Notes (office use)</i>	Arm or Hand Pain				Arthritis - Rheumatoid			Arthritis - Osteo			Back Pain (circle below) Upper Middle Lower			Joint Pain Where?			Leg or Foot Pain			Muscle Spasm/Cramp			Neck/Shoulder Pain									
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22. Gastrointestinal (check all that apply)

	Current	Past	Notes (office use)
Acid Reflux			
Belching			
Heartburn			
Changes in Appetite			
Constipation			
Diarrhea			
Stomach rumbling			
Epigastric Pain			
Abdominal Pain			
Flank Pain			
Gall Bladder Disease			
Liver Disease			
Hepatitis B or C			
Hemorrhoids			
Passing Gas			
Nausea/Vomiting			
Ulcers			

23. Genito-Urinary Tract (check all that apply)

	Current	Past	Notes (office use)
Blood in Urine			
Frequent Urination			
Frequent Night Urination			
Frequent UTI			
Heavy Flow			
Impaired Urination			
Kidney Disease			
Kidney Stones			
Painful Urination			

24. Endocrine (check all that apply)

	Current	Past	Notes (office use)
Diabetes Mellitus			
Hyperthyroid			
Hypoglycemia			
Hypothyroid			
Tendency to be more HOT or COLD <i>(please circle)</i>			
Preference for HOT or COLD <i>(please circle)</i>			
Aversion to HOT or COLD <i>(please circle)</i>			

25. Female Reproductive/Breasts (check all that apply)

	Current	Past	Notes (office use)
Bleeding btw. Cycles			
Clotting			
Heavy Flow			
Absence of Flow			
Spotting			
Irregular Cycles			
Painful Periods			
Premenstrual Problems			
Vaginal Discharge			
Menopausal Syndromes			
Difficulty Conceiving			
Breast Lump/Tenderness			
Nipple Discharge			

26. Menstrual/Birthing History
(please fill in appropriate boxes)

		Notes (office use)
Age of First Menses		
Length of Cycle		
# of Days of Menses		
# of Pregnancies		
# of Live Births		
# of Miscarriages		
# of Abortions		

27. Male Reproductive (check all that apply)

	Current	Past	Notes (office use)
Penile Discharge			
Prostate Problems			
Erectile Dysfunction			
Testicular Pain/Swelling			

28. Sexual History (check all that apply)

	Current	Past	Notes (office use)
Problems with Libido			
Contraceptive Use			
Current: _____			
Past: _____			
History of STDs			
Current: _____			
Past: _____			

Is there anything else we should know? _____

29. Lifestyle:

- a. Are you currently in a relationship? Y N
- b. Do you have any restrictions on your diet? Y N If so, please indicate? _____
- c. Do you have cravings for a particular food or flavor (i.e. sweet, salty, etc.)? _____
- d. Exercise routine: _____
- e. Spiritual practice: _____
- f. How many hours per night do you sleep? _____ What time do you go to bed? _____ Do you wake rested? Y N
- g. Occupation: _____ Employer: _____ Hours/Week: _____
Do you enjoy work? Y/N Why/Why not? _____
- h. Nicotine/Alcohol/Caffeine Use: _____
- i. Recreational Drug Use:
Current: _____ Past: (include when? for how long?) _____
- j. How many glasses (8oz.) of each do you drink per day? Soda: _____ Juice: _____ Tea: _____ Water: _____
- k. Interests, hobbies: _____

Additional Notes (Office use)