Dr. David A. Tucker, DACM, EAMP

12304 32nd Ave NE
Seattle, WA 98125

-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 M / F / Transgender 10. Marital: M S D W
11. Occupation _____ 12. Employer _____
    Employer's Address _____
    Street City State Zip

BRIEF CASE HISTORY

13. Chief Complaint _____
14. Complaint result of: Auto Accident Injury Job Related Other
15. Date of accident/Injury/Other ____ / ____ / ____
16. Have you seen any other doctor about this condition? _____ If yes, when? _____
17. Spouse's name _____ Occupation _____
    Employer _____ Address _____ Phone _____
18. Nearest relative not living with you _____
    Address _____ Phone _____
    Street City State Zip
19. In an 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? Cash Check Credit Card Health Insurance

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)

Referred by _____

The Zen of Healing
Dr. David A. Tucker, DACM, EAMP - Informed Consent

12304 32nd Ave NE
Seattle, WA 98125

I, the undersigned, hereby authorize David A. Tucker to perform the following procedures, but not limited to:

- **Acupuncture:** The insertion of pre-sterilized, disposable needles through the skin into the underlying tissues at specific points on the surface of the body.
- **Acupuncture Point Injection Therapy (APIT):** The injection of nutrients, homeopathics, or other approved substances into acupuncture points, Ashi points, and/ or trigger points.
- **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/plastic 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, numbness/tingling, 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.

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 Masters of Science in Acupuncture and Oriental Medicine from Bastyr University in 2005 and his Doctorate through Pacific College of Health and Sciences in 2021. He is a Licensed Acupuncturist or East Asian Medicine Practitioner (EAMP) in the State of Washington, holding Acupuncture License number AC2826, active from 2005.

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PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing The Zen of Healing. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of treatment and care. Refunds are not provided.

- This office **does not** verify insurance benefits. It is ***strongly recommended*** that each patient call their insurance carrier and have their benefits clarified to them including but not limited to – applicable co-pay, co-insurance, deductibles, # of visits, pre-authorization needed, etc.; we will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.

- Co-pays are due at the time of service.

- Patients are responsible for payment of co-pays, co-insurance, deductibles, standard units of time, and all other procedures or treatments not covered by their insurance plan.

- Co-insurance, deductibles and non-covered items will be billed by Medical Financial Specialists, Inc.

- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
    - Charge for returned checks
    - Charge for missed appointments without 24-hours notice (equal to return-office session fee)

By my signature below, I hereby authorize assignment of financial benefits directly to The Zen of Healing and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I have read, understand, and agree to the provisions of the Patient Financial Responsibility Form.

Signature: _____ Date:

The Zen of Healing
Dr. David A. Tucker, DACM, EAMP
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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), attorney or insurance offices, 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 206-696-1121.

Yours truly,

Dr. David A. Tucker
206-696-1121
David@thezenofhealing.com

The Zen of Healing
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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, 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, 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, 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, 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, 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. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and David A. Tucker, with respect to my identifiable health information.

David A. Tucker, 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

The Zen of Healing
Dr. David A. Tucker, DACM, EAMP
Patient Health History

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

Date of Birth: _____/_____/_____ Age: _____ Gender: M / F / Transgender 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.

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:**

Check those applicable:	Father	Mother	Brothers	Sisters	Spouse	Children
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:**

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

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

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

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

15. **Skin** *(check all that apply)*

	Current	Past	*Notes (office use)*
Acne	☐	☐	
Bruising	☐	☐	
Eczema	☐	☐	
Itching/Dryness	☐	☐	
Hives	☐	☐	
Jaundice	☐	☐	
Psoriasis	☐	☐	
Rashes	☐	☐	
Skin Changes	☐	☐	
Excessive Sweating	☐	☐	
Night Sweating	☐	☐	
Hair/Nail Changes	☐	☐	

16. **Head, Eye, Ear, Nose, and Throat** *(check all that apply)*

	Current	Past	*Notes (office use)*
Headaches	☐	☐	
Migraines	☐	☐	
TMJ/Jaw Problems	☐	☐	
Teeth Grinding	☐	☐	
Blurry Vision	☐	☐	
Glasses/Contacts	☐	☐	
Floaters in field of vision	☐	☐	
Tearing/Dryness	☐	☐	
Eye Pain/Strain	☐	☐	
Glaucoma	☐	☐	
Earaches	☐	☐	
Ear Ringing	☐	☐	
Impaired Hearing	☐	☐	
Nose Bleeds	☐	☐	
Sinus Problems	☐	☐	
Hay Fever	☐	☐	
Frequent sore throats	☐	☐	

17. **Blood, Lymphatic, Cancer, HIV** *(check all that apply)*

	Current	Past	*Notes (office use)*
Anemia	☐	☐	
Bleeding Easily	☐	☐	
Enlarged lymph nodes	☐	☐	
Transfusions	☐	☐	
Cancer	☐	☐	
HIV or AIDS	☐	☐	

18. **Musculoskeletal** *(check all that apply)*

	Current	Past	*Notes (office use)*
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	☐	☐	

19. **Neurological** *(check all that apply)*

	Current	Past	*Notes (office use)*
Loss of Balance	☐	☐	
Numbness/Tingling	☐	☐	
Paralysis	☐	☐	
Seizures/Epilepsy	☐	☐	
Vertigo/Dizziness	☐	☐	

20. **Cardiovascular** *(check all that apply)*

	Current	Past	*Notes (office use)*
Chest Pain	☐	☐	
Heart Disease	☐	☐	
Heart Murmurs	☐	☐	
High Blood Pressure	☐	☐	
Palpitations/Fluttering	☐	☐	
Stroke	☐	☐	
Swelling of Ankles	☐	☐	
Varicose Veins	☐	☐	

21. **Respiratory** *(check all that apply)*

	Current	Past	*Notes (office use)*
Asthma	☐	☐	
Difficulty breathing	☐	☐	
Emphysema	☐	☐	
Frequent Colds	☐	☐	
Persistent Cough	☐	☐	
Pneumonia	☐	☐	
Shortness of breath	☐	☐	
Tuberculosis	☐	☐	
Other:	☐	☐	

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 *(please circle)*			
Preference for HOT or COLD *(please circle)*			
Aversion to HOT or COLD *(please circle)*			

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)