

De Yi Tang

Patient Health History Questionnaire

Welcome to our clinic! Please fill out this questionnaire completely. All of your answers will be held confidential. If you have questions, please ask us. If there is anything you wish to bring to our attention that is not asked on this form, please note it in the "Comments" section. Thank You!

Today's date: _____

Name: _____

Street address: _____
Last First M Apt #:

City: _____ State: _____ Zip code: _____

Birthdate: _____ Age: _____ Height: _____ Weight: _____

SS#: _____ M/F: _____ Marital Status: _____

Home phone: _____ Cell phone: _____

Employer: _____ Work phone: _____

Emergency contact: (with phone #): _____

Type of insurance: _____

Referred by: _____

E-mail: _____

Your primary doctor Name: _____ Phone: _____

Address: _____

Referred from doctor name: _____ Phone: _____

Address: _____

Please describe your main complaints: _____

Are you pregnant? _____ Allergies? _____

Are you taking any western medicines, herbs, vitamins? _____ Please list: _____

Any surgeries or major illnesses? _____

Family health history (parents, siblings, children): _____

Additional comments? _____

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I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

We are committed to your health and well-being. All of us affiliated with this center believe that while Oriental medicine, has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, we recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment. To comply with Article 160, Section 8211.1(b) of NYS Education law, we request that you read and sign the following statement:

We, the undersigned, do affirm that _____ (patient) has been advised by an acupuncturist to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment, and any conditions which may be disclosed during the examination and treatment sessions.

X _____
Patient Signature

Date

II. INFORMED CONSENT TO ACUPUNCTURE TREATMENT

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) which may be recommended are traditionally considered to be safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, as stomachache, vomiting, diarrhea, rashes, hives and tingling of the tongue. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbal preparations. **Initial: X** _____

As of today's date, I (circle one) AM/AM NOT pregnant. I will notify each clinical staff member who is caring for me if I am or become pregnant. **Initial: X** _____

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time based upon the facts known to them, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports and that portions of my records may be used for research purposes, however, my name and identifying information will not be disclosed. Otherwise any of my records will be kept confidential and will not be released to any party without my written consent.

I hereby grant Dr. Decheng Chen permission to use my image and video in any and all publications, including website entries, without payment or any other consideration.

To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated) and clinical staff providing information and obtaining consent.

III. Consent, Authorization & Disclaimer, waiver of liability

I listed and signed below consent and agree stated below. I hereby consent and grant New York licensed acupuncturist Dr. Chen Decheng to perform Traditional Chinese Medicine (TCM) including Herbal Formula for my symptoms. I understand and acknowledge that, during the current development of this new pandemic virus, the condition of this disease changes abnormally and develops rapidly, and the consequence or result of TCM treatment is unpredictable. I hereby declare and agree that all the consequences and liabilities arising from the use of TCM and Chinese herbs Formula from Dr. Decheng Chen will be borne by me solely. I, my family, company and any related parties hereby agree to waiver any liability of Dr. Chen and his related entities arising from treatment, and agree not to take any action including legal action against Dr. Chen and his related entities regarding any liabilities in connection with the treatment, including legal, financial and other liabilities.

IN WITNESS WHEREOF, the Patient and/or undersigned have caused this Consent, Grant, Disclaimer and Waiver of Liability to be executed at date below.

X _____
Signature of patient or representative

Date