□ 903 S. Friendswood Dr. □ Friendswood, TX 77546 □ 281.612.2116

YIN & YANG Healthcare

CONFIDENTIAL PATIENT INFORMATION

Name: _____ **Date**: _____

How did you hear about us? ☐ Google / FB / yelp ☐ Insurance ☐ Location ☐ Zocdoc

☐ Referred by_____

Date of Birth: _____ **Sex**:_____ **Marital Status**: _____

Height: _____ **Weight**: _____

Occupation: _____ **Employer**: _____

Home Address: _____ City _____ TX _____

Email Address: _____

Important:
Free e-newsletter will be sent at this email address regarding alternative medicine and health tips, etc.

Phone (cell): _____ (home): _____ (work): _____

Name of spouse / parent: _____ **Date of Birth**:_____

Whom may we contact in case of emergencies? **Name**: _____

Relationship to patient:_____**Phone**:_____

CLINIC POLICY REQUIRES PAYMENT AT THE TIME OF SERVICES.

I hereby authorize **Hui Ouyang, DC, LAc** and **YIN & YANG Healthcare LLC** to release my personal and medical information to my insurance company, adjustor or attorney should it be necessary. I further authorize and direct the health / accident insurance company and/or the attorney, to pay directly to **Hui Ouyang, DC, LAc** and **YIN & YANG Healthcare LLC**, for professional services rendered me. This is to act as an **assignment of the rights and benefits** to the extent of all services provided. I also understand that if I suspend or terminate my care and treatment, any fees for all services rendered me will be immediately due and payable. Furthermore, any charges, fees, or court costs incurred as a result of collection efforts will be added to my account balance.

Patient / Guardian Signature:_____**Date**:_____

Application for Treatment: History

Name:_____Date:_____

What is your complaint? Where? _____

How did it begin? After a fall / lifting / over-reaching / sleep or posture or overwork or stress or unknown _____ Type? acute / chronic / recurring / sub-acute

When date was this condition noticed? _____ _____ _____

Any past episodes of this complaint? _____

What is quality of discomfort? Frequency?

aching / annoying / burning / deep / diffuse / dull / heavy / intolerable / numbness / pulling / sharp / shock / sore / stabbing / stiffness / throbbing / tightness / tingling

25%☐Intermittent 50%☐Occasional 75%☐Frequent 100%☐Constant

Is the discomfort going down to the arms or legs? Yes / No and Where?_____

How is this condition progressing? ☐ Worse ☐ Better ☐ Same

What is the VAS? 0 1 2 3 4 5 6 7 8 9 10 (Excruciating)

Condition relived by? _____or nothing

It aggravated by? _____ or almost any movement

Have you seen any other practitioners for this condition? MD / DC / PT / LAc

If yes, name, type, and dates seen:_____

What did they recommend?_____

Have any recent diagnostic images or tests been performed? _____

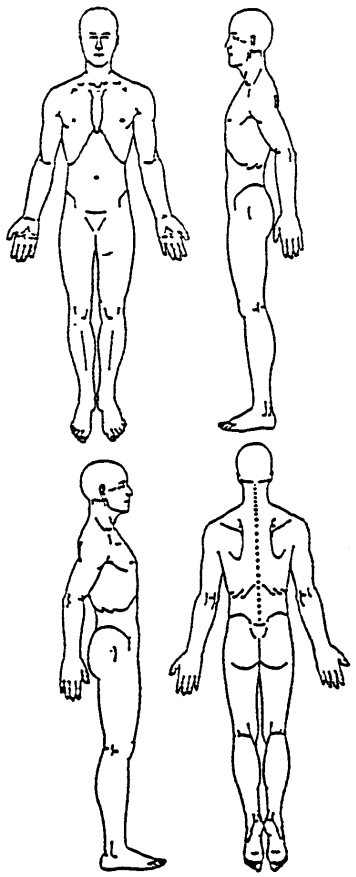
What are your specific therapeutic goals? _____

What movements do you have difficulty performing? _____

What Activity of Daily Living was most affected?

working / homemaking / social life / personal care (washing,dressing,etc.) / sleeping / sitting / standing / walking / driving

Mark Affected Areas below:



List all auto accidents and/or Major Traumas: ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Please describe: _____

If Injury or Accident Please complete these questions: Date injured: _____Time: _____

Have you lost any days of work? _____ Dates:_____

Please describe how your accident happened:_____

Company of person responsible for injuries:_____

Attorney's name (if applicable):_____ Address:_____ Phone: _____

Auto Accident Only: You were ☐ Driver ☐ Passenger ☐ Pedestrian, In a ☐ Car ☐ Truck ☐ Other _____

Your vehicle: ☐ Struck the other(s) ☐ Was struck by the other(s) ☐ Undetermined

Approximate size and speed of your car _____= _____M/H, Other car _____= _____M/H

Part of your vehicle hit: ☐ Back ☐ Front ☐ Right side ☐ Left side ☐ Other _____

You were wearing: ☐ Seatbelt ☐ Shoulder harness ☐ Airbag deployed. Were the police noticed? Yes / No

Did you brace for impact? Yes/No. You were looking: ☐ Forward ☐ Left ☐ Right Did head hit headrest? Yes/No.

Did you strike the interior of the vehicle? Yes/No. With what part of your body?_____

Did you lose consciousness at any point? Yes/No, Were you treated by medical personnel for injuries? Yes/No

CONFIDENTIAL PATIENT INFORMATION

Please fill in all portions of this form. If you need help, please ask.

Name: _____ **Date**: _____

Reason(s) for Visit_____

Current Symptoms: Please check all that apply

FEVER and CHILLS
☐ Aversion to ☐ Cold ☐ Heat
☐ Aversion to Wind
☐ Fever and Chills Alternatively
☐ Fever and Chills Simultaneously
☐ High ☐ Low Fever
☐ Fever Intermittently
☐ Night Fever
☐ **PERSPIRATION**
☐ No Sweating
☐ Profuse Sweating
☐ Spontaneous Sweating
☐ Sweating at Night
☐ Sweating in the Palm

SKIN
☐ Bruising Easily
☐ Change in Moles
☐ Dry Skin / Itching
☐ Rash / Sensitive Skin
☐ Sores that Won't Heal

NEUROLOGICAL
☐ Anxiety ☐ Panic
☐ Depression
☐ Difficulty Concentrating
☐ Dizziness
☐ Epilepsy / Seizures
☐ Irritability
☐ Memory Loss
☐ Numbness ☐ Tingling
☐ Tremors
☐ Weak Muscles

HEAD/EYE/ENT
☐ Blurred Vision
☐ Cataracts
☐ Chronic Ear Infections
☐ Dry Eyes
☐ Ear Ringing
☐ Headache ☐ Migraine
☐ Hearing Loss
☐ Loss of Taste ☐ Smell
☐ Nasal Congestion
☐ Post Nasal Drip
☐ Runny Nose
☐ Sore Throat
☐ Swollen Lymph Nodes
☐ TMJ Problems

MUSCULOSKELETAL
☐ Arthritis
☐ Ankle Pain
☐ Back Problems
☐ Elbow Pain
☐ Heel ☐ Foot Pain
☐ Hip ☐ Pelvis Problems
☐ Knee Pain
☐ Lack of Coordination
☐ Neck ☐ Shoulder Pain
☐ Poor Posture
☐ Scoliosis
☐ Muscle Pain
☐ Stiffness
☐ Swollen Joints
☐ Wrist ☐ Hand Pain

GASTRO-INTESTINE
☐ Abdominal Pain
☐ Bloating
☐ Constipation
☐ Diarrhea
☐ Difficult Swallowing
☐ Eating Disorders
☐ Gas
☐ Heartburn
☐ Hemorrhoids
☐ IBS
☐ Indigestion
☐ Nausea / Vomiting
☐ Rectal Bleeding
☐ Stomach Pain

HEART/LUNGS
☐ Apnea
☐ Chest Pain or tightness
☐ Coronary artery disease
☐ Cough ☐ Wheezing
☐ Emphysema
☐ High Blood Pressure
☐ High Cholesterol
☐ Lower extremity edema
☐ Pneumonia
☐ Poor Circulation
☐ Rapid Heart Beat
☐ Shortness of Breath
☐ Snoring Issues
☐ Tuberculosis
☐ Varicose Veins

MALE ONLY
☐ Discharge from Penis
☐ Erection Difficulties
☐ Lump in Testicle
☐ Sore on Penis

FEMALE ONLY
☐ Abnormal Pap Smear
☐ Bleeding between Periods
☐ Breast Lump
☐ Heavy Bleeding
☐ Hot Flashes
☐ Painful Intercourse
☐ PMS
☐ Vaginal Discharge
☐ Vaginal Dryness

ENDOCRINE
☐ Cold Hands and Feet
☐ Heat ☐ Cold Intolerance
☐ High Blood Sugar
☐ Hyper ☐ Hypothyroidism
☐ Osteoporosis ☐ Osteopenia
☐ Rheumatism
☐ Steroid Treatments
☐ Testosterone deficiency

URINARY
☐ Bloody Urine
☐ Dribbling
☐ Kidney Stone
☐ Frequent Infections
☐ Painful / Frequent Urination
☐ Lack of Bladder Control

MEDICATIONS / VITAMINS / SUPPLEMENTS
Please List all medications and dosages
☐ Pain Killers_____
☐ Muscle Relaxers_____
☐ Blood Pressure_____
☐ Birth Control Pills_____
☐ Diabetes_____
☐ Herbs_____
☐ Vitamins_____
☐ Supplements _____
☐ Others_____

ALLERGIES
Please List:
☐_____
☐_____
☐_____
☐_____
☐_____
☐_____

HEALTH HABITS
Please check which substances you use and list how much:
☐ Coffee: _____
☐ Tobacco: _____
☐ Alcohol: _____
☐ Drugs: _____
☐ Other: _____

Did you have any **transmitted diseases**? ☐COVID-19 ☐AIDS ☐Hepatitis ☐Other(s): _____

PAST or CURRENT ADDITIONAL CONDITIONS

Please check (✓) any conditions you have had.

☐ AIDS	☐ Chicken Pox	☐ High Cholesterol	☐ Prostate Problems
☐ Alcoholism	☐ COVID-19	☐ HIV Positive	☐ Psoriasis/Eczema
☐ Allergies	☐ Diabetes	☐ Kidney Disease	☐ Psychiatric Care
☐ Anemia	☐ Emphysema	☐ Leg Cramps	☐ Rheumatic Fever
☐ Anorexia	☐ Epilepsy	☐ Liver Disease	☐ Sinusitis
☐ Appendicitis	☐ Gall Bladder Disease	☐ Measles	☐ Stroke
☐ Arthritis	☐ Glaucoma	☐ Migraine Headaches	☐ Suicide Attempt
☐ Asthma	☐ Goiter	☐ Miscarriage	☐ Thyroid Problems
☐ Bleeding Disorders	☐ Gonorrhea	☐ Mononucleosis	☐ Tonsillitis
☐ Breast Lump	☐ Gout	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Bronchitis	☐ Heart Disease	☐ Mumps	☐ Typhoid Fever
☐ Cancer	☐ Hepatitis	☐ Pacemaker	☐ Ulcers
☐ Cataracts	☐ Herpes	☐ Pneumonia	☐ Vaginal Infections
☐ Chemical Dependency	☐ High Blood Pressure	☐ Polio	☐ Venereal Disease

FAMILY HISTORY

Relation:	Father	Mother	Sibling 1	Sibling 2	Child 1	Child 2
Age if living:						
Age at Death:						
Cause of Death:						

Please check if any of the following conditions applied to the above relatives:

Immune Disease:	☐	☐	☐	☐	☐	☐
Cancer:	☐	☐	☐	☐	☐	☐
Diabetes:	☐	☐	☐	☐	☐	☐
Heart Attack/Stroke:	☐	☐	☐	☐	☐	☐
Heart Disease:	☐	☐	☐	☐	☐	☐
High Blood Pressure:	☐	☐	☐	☐	☐	☐
Mental Illness:	☐	☐	☐	☐	☐	☐
Osteoporosis:	☐	☐	☐	☐	☐	☐
TB:	☐	☐	☐	☐	☐	☐

HOSPITALIZATIONS, SURGERIES AND MAJOR ILLNESSES

	Year	Condition or Procedure	Outcome
☐			
☐			
☐			
☐			

PREGNANCY HISTORY

Number of Pregnancies: _____

Number of Live Births: _____

Check if you've had any of the following:

☐ Abortion ☐ Miscarriage ☐ Preemie

MENSTRUATION

Last Menstrual Period: _____

Last Pap Smear: _____

Have you had a Mammogram? _____

Check if you've had any of the following:

☐ No periods ☐ Delayed ☐ Early ☐ Irregular

☐ Painful periods ☐ PMS

☐ Scanty periods ☐ Heavy periods

☐ Brown Red ☐ Dark Red ☐ Excessive clots

SLEEPING PATTERN

How many hours per night? _____

Please check if you have any of the following:

☐ Frequent Waking ☐ Nightmares ☐ Snoring

☐ Nap during day ☐ Sleep walk ☐ Grind Teeth

OCCUPATION

Check if you are exposed to: ☐ Stress

☐ Heavy Lifting ☐ Hazardous Substances

EXERCISE

How often do you exercise? _____

What type? _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

PATIENT RECORD, IMAGE AND VOICE OF DISCLOSURES

In general, the HIPPA privacy rule gives patients the right to request a restriction on the uses and disclosures of their protected health information (PHI). The individual is also given the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's residence. We would like to respect those rights in every way possible and request that you fill in the following:

I wish to be contacted in the following manner (check all that apply):

☐ Cell Telephone_____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work address

☐ Email: _____

Date	Disclosed to Whom Address/Fax	(1)	Description of Disclosure Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if Disclosure is authorized
(2) Type Key: T= Treatment Records P= Payment Information O= Healthcare Operations
(3) Enter how disclosure was made: F=Fax; P= Phone ; E= Email; M= Mail; O= Other

I hereby voluntarily and without compensation, authorize images and/or voice recording(s) to be made of me by YIN & YANG Healthcare LLC and _____.

I understand that said images and/or voice recordings are intended for use of legitimate business or educational purposes for the clients' organization. Such purposes include but are not limited to, internal and external educational purposes, promotional materials, training and advertisements.

I have read and understand the foregoing and I consent to the use of my image and/or voice as specified for the above named purpose(s). I further understand that no royalty, fee or other compensation of any kind shall become payable to me for the use of my image and/or voice.

_____ _____
Patient Signature Date

_____ _____
Print Name Birthday

Privacy regulations generally require healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.
Healthcare entities must keep records of PHI disclosures. Information provided above, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Informed Consent to Chiropractic and Acupuncture Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

The nature of acupuncture treatment: The doctor may also use acupuncture as an adjunct, or in whole, during your care. Acupuncture involves the insertion of tiny needles into the body through the skin. It may also involve the use of pressure, electrical stimulation.

Possible Risks: As with any health care procedure, complications are possible following a **chiropractic manipulation**. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. **Acupuncture** is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolves with pressing dry cotton on the spot where the skin is bleeding. It is also normal for the patient to have a temporary sore, pressure, numb, burning or tingling sensation at the acupuncture site and even radiating to certain regions of the body. There have been rare instances reported of fainting, infections and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. **Chinese herbs** that have been recommended are traditionally considered safe in the practice of traditional Chinese medicine. Some herbs may be inappropriate during pregnancy. If any gastrointestinal upset or allergic reactions are experienced with the herbs, discontinue immediately and consult your doctor.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare". The probability of adverse reaction due to acupuncture and Chinese herbs are also considered "rare". They would be significantly less than the chance of adverse complication due to prescription medication use, mediation injection or surgery.

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had any unusual risks of my case explained to me. I have read the explanation above of chiropractic and acupuncture treatments. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatments and understand that no guarantees of outcome have been made. I have freely decided to undergo the recommended treatments and herby give my full consent to treatments.

_____	_____	_____
Printed Name	**Signature**	**Date**

WITNESS:

_____	_____	_____
Printed Name	**Signature**	**Date**