



www.DrTeresaChen.com

Chen T. Acupuncture, Herb & Nutrition

12501Bel-Red Road Suite 110 Bellevue, WA 98005 (206)-818-8012

Name of Patient: _____, **Date of Birth:** ____/____/____, **Age:** ____
(Please Print) First Middle Last Month Day Year

Marital Status: Single Married Widowed Divorced, **Gender:** Male Female

Social Security No.: ____ - ____ - ____, **Employed By:** _____, **Occupation:** _____

Home Address: _____, _____, _____
Street City State

Zip

Telephone: Home: (____) ____ - ____, Business: (____) ____ - ____
Cellular: (____) ____ -- E-Mail Address: _____

Health Insurance Name: _____, **Plan:** PPO HMO Kaiser Others _____

Insured Name: _____, **Insured Date of Birth:** ____/____/____
First Middle Last Month Day Year

Insured Social Security No.: ____ - ____ - ____, **Insured Employed By:** _____, **Insured Occupation:** _____

Insured Home Address: _____, _____, _____
Street City State

Zip

Major Complaint: _____

Height: _____ **Weight:** _____ **Did you see Acupuncturist before?** No Yes When _____ Where _____

Surgery: 1. _____, 2. _____, **Medication:** 1. _____, 2. _____

Patient's Medical History [Please circle problem(s) below]

bronchitis / asthma / emphysema	anemia / epilepsy / stroke	hypo / hypertension
psoriasis / eczema / rash / hives	diabetes / hepatitis / heart disease	hypo / hyperglycemia
hay fever / allergy / rhinitis / sinusitis	T.B / peptic ulcer / cancer	hypo / hyperthyroid
migraine / headache / tension / nervous	fatigue / insomnia / depression	glaucoma / cataract
bursitis / tendonitis / arthritis / rheumatism	obesity / alcoholic / smoking	prostate / shingles
tinnitus / nerve deafness	Bell's paralysis / drug addiction	whiplash / sciatica
infertile / dysmenorrhea / menopause	Others _____	

病史 (请在相应病情处画圈)

气管炎 / 哮喘 / 肺气肿	贫血 / 癫痫 / 中风	
低血压 / 高血压		
牛皮癣 / 湿疹 / 发疹 / 荨麻疹	糖尿病 / 肝炎 / 心脏病	低血糖 /
高血糖		
花粉症 / 过敏 / 鼻炎 / 副鼻腔炎	结核病 / 消化性溃疡 / 癌症	甲
甲状腺功能低下 / 亢进		
偏头痛 / 头痛 / 紧张 / 焦虑	疲劳 / 失眠 / 抑郁症	青
光眼 / 白内障		
滑囊炎 / 肌腱炎 / 关节炎 / 风湿	肥胖症 / 嗜酒 / 吸烟	前列腺炎
/ 带状疱疹		
耳鸣 / 神经性耳聋	面神经瘫 / 吸毒	颈部扭伤
/ 坐骨神经痛		
不孕 / 月经不调 / 更年期综合症	其它 _____	

In Case of EMERGENCY Please Contact:

Name: _____, **Gender:** Male Female, **Telephone:** (____) ____ - ____

Relation: _____, **Address:** _____
Street City State Zip

I certify that the information above is true and correct. I wish to participate in acupuncture and related therapies on my own free will. I understand there is a slight risk of minor complications associated with this procedure, such as bruising, rash or allergic reactions. I understand that the treatments I will receive are not guaranteed to eliminate or to alleviate (lessen) my present condition of complaints for which I am seeking therapy. I will authorize the release of necessary information for insurance claims. I also authorize payment of my insurance benefits to Teresa Teli Chen L. Ac. for service provided. I will be responsible for all payments of treatment received regardless of insurance coverage.

Signature: _____, **Date:** ____/____/____