Case #. _____ *Date* ___/___/_____

Morningsun Health Care

INITIAL HEALTH HISTORY FORM

In order to serve you properly we will need the following information. (PLEASE PRINT) All information will be strictly confidential.

Patient Name: First_____ Middle_____ Last_____ Gender: ____ Occupation_____

Date of Birth ____/____/____ Telephone #. _____ Address_____

Would you like to be contacted by email with informational newsletters and special clinic offers?

If Yes □ Email Address: _____ No □

What is your chief complain: a: _____ b: _____ c: _____

How long have you had this condition: a: _____ b: _____ c: _____

What other treatment have you or are currently receiving for relief of this condition? _____

_____

If you are having pain please rate on the 1-10 scale, 10 being the highest: 1 2 3 4 5 6 7 8 9 10

Please rate your energy level on a 1-10 scale, 10 being the highest: 1 2 3 4 5 6 7 8 9 10

Please rate your sleep quality on a 1-10 scale, 10 being the best: 1 2 3 4 5 6 7 8 9 10

Are you taking any medication, herbal remedy, vitamins, or other nutritional supplement at this time?

	Medication Name	**Method**		**Medication Name**	**Method**
Example	Lipitor	20mg once /day	**4**		
1			**5**		
2			**6**		
3			**7**		

Are you carrying a pacemaker? Yes___ No___ If yes, date placed _____

Are you subject to any nervous disorders, dizzy spells, or fainting? _____

(Woman) **Pregnancy History:**

Currently Pregnant? If yes, for how long? _____If no, last Period Date_____

Total Pregnancies____Living____Ectopic___Misscariages___Induced Abortions____

Diet: Please describe the time and type of foods you eat regularly:

Breakfast _____

Morning Snack_____

Lunch_____

Afternoon Snack_____

Dinner_____

Evening Snack_____

Case #. _____ *Date* ___/___/_____

Morningsun Health Care Health History Form **Patient Name:**

Drug Allergies _____**Latex Allergy?**_____

Family History: Complete for each family member, placing an X in the appropriate box:

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Tuberculosis							
Blood Disorder							
Diabetes							
High Blood Pressure							
Stroke							
Seizures							
Heart Disease							
Liver Disease							
Kidney Disease							
Cancers or Tumors							
Drug Abuse							
Depression/Mental Illness							
Other							

Major Hospitalizations (If you have ever been hospitalized for any serious medical illness or operation):

Operation/Illness/Procedure	Year	Name of Hospital	City / State

HABITS: Please check any of the habits listed below which apply to you now or in the past.

Coffee ☐ yes ☐ no cups per day/week___/__ age started: ____ age quit: ____

Tobacco ☐ yes ☐ no # cigarettes per day____ age started: ____ age quit: ____

Marijuana ☐ yes ☐ no use per day/week ___/__ age started: ____ age quit: ____

Alcohol ☐ yes ☐ no use per day/week ___/__ age started: ____ age quit: ____

Crack/Cocaine ☐ yes ☐ no use per day/week ___/__ age started: ____ age quit: ____

Heroin ☐ yes ☐ no use per day/week ___/__ age started: ____ age quit: ____

Other

Case #. _____ *Date* ___/___/_____

Morningsun Health Care- Initial Health History Form **Patient Name:**

Patient Status: Social Security # (optional) : _____Referred to our Clinic By: _____

Married ___ Single ___ Divorced ___ Widowed ___ Partnered ____ Other _____

Emergency Contact: _____ Relationship: _____Telephone #: _____

Employment Status: Full Time ___ Part Time___ Retired ___ Unemployed ___ Student ___

Employer's Name: _____ Telephone #: _____ Employer's Address: _____

Primary Health care source: Physician's Name:_____ Telephone #: _____

Physician's Address: _____ Date of last visit: _____

What are you being treated for? _____

Cancellation Police: We ask patients to provide us with **24 HOURS NOTICE WHEN CANCELLING** or rescheduling appointments. When shorter notice or a no-show occurs, the patient will be subject to a **$15 SERVICE CHARGE.**

Patient or Guardian Signature: _____ Date: _____

Skip to Page 4 if your medical insurance does not cover acupuncture.

Medical Insurance status: Self ___ Private Insurance ___ Medi –Cal___ Workmen's Comp___ Other _____

Primary Insurance: _____ Telephone #: _____

Insurance Billing Address: _____

Policy Holder's Name: _____ Relationship: _____
Policy # / ID #: _____ Group #: _____
Secondary Insurance: _____ Telephone #: _____

Insurance Billing Address: _____

Policy Holder's Name: _____ Relationship: _____
Policy # / ID #: _____ Group #: _____

Insurance Responsibility Statement:

Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our clinic. It is your responsibility to pay the deductible, co-payment, and any other balances not paid by your insurance. We will assist you in billing your insurance company as much as possible. However, you are responsible for your bill.

Assignment and Release: I hereby assign my insurance benefits to be paid directly to the provider of service. I understand that I am financially responsible for any non-covered services. I also authorize the provider to release any information required to process any claims.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Case #. _____ *Date* ___/___/_____

Notice of Privacy Practices

Our Pledge Regarding Medical Information:

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information. This notice will remain in effect until it is replaced or amended by changes in law.

Use and Disclosure of Your Medical Information

We gather personal health information in several ways. This information comes from you, from other healthcare providers, and from third party payers. This section describes different ways that we use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us. We may use and disclose your medical information in the following ways:

- For treatment
- For payment
- For healthcare operations
- When required by law

This office will not use your health information for marketing communications without your written authorization. However, this office may send newsletters and appointment reminders, by telephone calls or e-mail.

Patient Rights

1. Upon written request, you have the right to access, review or receive copies of your health care records. There is a copy fee of $15 and with 10 working days to process it.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your protected health information.
4. You have the right to request that we amend your protected health information; the request must be in writing.
5. You have the right to receive all notices in writing.

If you have questions, complaints or want more information, please contact Dr. Qinyu Wang at (415)539-5209

Morningsun Health Care Address: 851 Burlway rd, suite 309, Burlingame, CA94010

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have read, reviewed, understand and agree to the statement

of the Privacy Practices for healthcare services in this office.

This practice has attempted to provide each patient with a statement of Privacy Practices.

Patient or Guardian Signature _____ **Date**_____