**Liying Acupuncture Healing Service**
**8975 Guilford road #170, Columbia, MD 21046**
**11820 Parklawn Drive #140, Rockville, MD 20852**
**Tel: (443) 453 7727**

# CLINICAL TREATMENT FORM – Acupuncture - 

Patient Name______________________ (Last / First / Initial) Sex M / F Birthdate___ / ___ / ______ (mm / dd / yyyy) Today Date ______________

Address ______________________ City/State/Zip ______________________

Home phone ______________ Cell phone ______________ Work phone ______________

Marital status: ☐ S ☐ M ☐ W ☐ D ☐ Sep. Race: ☐ Caucasian ☐ Black ☐ Asian ☐ Hispanic ☐ Other

Occupation: ______________________ Religion: ______________________

**Insurance:** ______________________

Subscriber Name______________________ Subscriber ID #______________ Employer______________

Health Plan______________________ ☐Primary ☐Secondary Group #______________ Is this? ☐Work Related? ☐Auto Related?

PCP Name Phone #______________________

**CONDITION TREATED, DIAGNOSIS AND ICD-9 CODE**

1______________________ __________
2______________________ __________
3______________________ __________
4______________________ __________

☐ Acute Condition ☐ Chronic Condition ☐ Continuing Care
☐ Co-managed Care ☐ Supportive Care

**Eastern Diagnoses:**
______________________ ______________________

**TREATMENT/SERVICES SUBMITTING FOR REVIEW**

Date: From ___ / ___ / _____ Through ___ / ___ / _____
Total # Office Visits/Acupuncture______________
☐ Established Patient Exam Date______________
Estimated Date of Release_______ / _______ / _______

☐ Acupuncture ☐ Electro-stimulation ☐ Acupressure/Tui-Na ☐ Home Care Advice
☐ Diet ☐ Cupping ☐ Cold/Heat Pad ☐ GuaSha ☐ Herbs ☐ Infrared/Heat Lamp
☐ Moxibustion ☐ Rehab Exercise ☐ Nutritional Supplements______________
☐ Other______________________

**Treatment Goal**:

**Services provided prior to today and the treatment outcome:**

Total # of Treatments _____ performed. Patient's response to care______________________

Pain has ☐ Decreased ☐ No Change ☐ Worsened ☐ Decreased only for a short period of time______________

Functional Ability Change ☐ Improving ☐ No Change ☐ Getting Worse. Explain:______________

**Current main complaint(s)** ______________________

______________________

**Mechanism of injury/date of onset** ☐ Traumatic ☐ Repetitive ☐ Exacerbation ☐ Recurrent / Chronic ☐ Unknown ☐ Post-Surgical ________

**Pertinent health history** ______________________

**Other ongoing treatments (e.g., medications, therapies)**______________________

______________________

**Height**__________, **Weight** ___________lb, **BP**_____ / ______ mmHg, **Temperature** ______________, **Pulse** __________

**Summary of your examination findings (or attach page 2): Date of exam** _____ / ____ / ______ **Findings**: ______________

______________________

Activities of Daily Living are ☐normal ☐ mildly affected ☐ severely affected: ______________

Observation______________________

Palpation______________________

Range of Motion______________________

Orthopedic Testing______________________

Neurological Assessment______________________

**Tongue Signs**______________, **Pulse Signs R:** ______________ **L:** ______________

**Additional Clinical Findings**______________________

**Signature of treating acupuncture provider**______________________ **Date**______________

## Acupuncture Clinical Findings

Patient Name________________________ Occupation_________________ Provider Name______________________________

## Pain Descriptions:

Pain Condition #1: Location _______________ Intensity (1-10) _____ Frequency_______________ Duration________ hours/days

Pain is ☐Sharp ☐Dull ☐Stabbing ☐Burning ☐Spasmodic ☐Tingling ☐Throbbing ☐Stiffness ☐Distension or __________

Aggravating factors:__________________________________ Alleviating factors:________________________________

Pain Condition #2: Location ______________ Intensity (1-10) _____ Frequency ___________________ Duration_______hours/days

Pain is ☐Sharp ☐Dull ☐Stabbing ☐Burning ☐Spasmodic ☐Tingling ☐Throbbing ☐Stiffness ☐Distension or __________

Aggravating Factors:_____________________________________ Alleviating Factors:______________________________

Other Pain Conditions:______________________________________________________________________________

## Clinical Findings Related to Pain Location:

**Head:**

Pain with ☐Nausea/Vomiting ☐Fever/Chills ☐Dizziness ☐Phono/Photophobia ☐Neck Rigidity

Neurologic Deficit ☐Sensation ☐Strength ☐Speech ☐Vision ☐Hearing ☐Cognition ☐Memory ☐Eye Motion/Pupils React

**Neck:**

Tenderness at _____________ ☐Mild ☐Moderate ☐Severe ☐Worsened. Muscle Spasm ☐Mild ☐Moderate ☐Severe

Postural Abnormalities_______________________________ Radiating Pain To_________________________________

Functional Limits______________________________________________________________________________

**Back:**

Tenderness at _______________ ☐Mild ☐Moderate ☐Severe ☐Worsened. Muscle Spasm ☐Mild ☐Moderate ☐Severe

Postural Abnormalities _______________ ☐Scoliosis ____________________ Radiating Pain To__________________

Functional Limits______________________________________________________________________________

**Extremities, Hip(s) and Shoulder(s)**

Tenderness at _______________ ☐Mild ☐Moderate ☐Severe ☐Worsened. Muscle Spasm ☐Mild ☐Moderate ☐Severe

Swelling _______________ Color change __________ Deformity ______________ Radiating pain to__________________

Functional Limits______________________________________________________________________________

Neurologic Deficit Location ___________________________ ☐Weakness ☐Abnormal Sensation ☐Reflexes (Increased/Decreased)

**ROM of Affected joint(s**) Use measurement or indicate if ROM Within Normal Limits (WNL), mildly, moderately or severely limited:

| **Joints** | Flexion / Extension | Lateral Flexion R / L | Rotation R / L | Rotation Int./Ext. | Abduction / Adduction | Other: |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Orthopedic/Neurological Test Findings:** E.g., Axial Compression ______ ; Patrick's (Fabere) _______ ; Straight Leg Raising_______

______________________________________________________________________________________________

**Abdominal Pain:**

Associate Symptoms: ☐Fever ☐Nausea/Vomit ☐Gas/Distension ☐Heartburn/Reflux ☐Constipation ☐Diarrhea or________

Palpable Mass at ___________________Tenderness at______________ Rebound Tenderness_______________________

Bowel Movement Sounds (Increase/Decrease)____________________ Other Findings______________________________

**Menstrual Pain:** Menstrual Cycle________ days. Other Symptoms______________________________________________

**Additional Clinical Findings (including Lab / Radiographic Exams)**__________________________________________

______________________________________________________________________________________________

**Outcome Assessments (List both Initial and Current date(s) with score(s) for applicable tests)**

| | **Initial** | **Current** | | **Initial** | **Current** |
|---|---|---|---|---|---|
| **List Date Obtained** | ____ / ____ / ____ | ____ / ____ / ____ | **List Date Obtained** | ____ / ____ / ____ | ____ / ____ / ____ |
| Roland-Morris score | ______________ | ______________ | Neck Disability Index score | ______________ | ______________ |
| Oswestry score | ______________ | ______________ | LEFS (Lower Extrem.) score | ______________ | ______________ |
| Pain scale (0-10) score | ______________ | ______________ | DASH (Upper Extrem.) score | ______________ | ______________ |
| Other______________ | ______________ | ______________ | Other___________________ | ______________ | ______________ |

**Signature of treating acupuncture provider**______________________________ **Examination Date (required)**_____________

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# INITIAL HEALTH STATUS

**Acupuncture**

Patient Name______________________________ Birthdate_____________Primary Language_____________ Sex M / F
Last First

Address___________________________ City________________ State_____ Zip________ Primary Phone____________

Employer_________________________ Occupation______________________ Other Phone______________________

Subscriber Name_________________________ Subscriber ID #________________Group #_____________________

Primary Health Plan____________________________________ Patient/Member ID #_____________________________

2nd Health Plan_______________ Primary Care Physician (PCP)_________________ PCP Phone #______________
(Required) (Required)

**Are you under the care of a physician?** ☐ **No** ☐ **Yes, for what conditions?**___________________________

**Please describe your current health problem(s)**___________________________________________________________

**How and When it began**________________________________________________________ Is this work related? Y / N

What treatment have you received for the above condition(s)? ☐ Surgery ☐ Medications ☐ Physical Therapy
☐ Injections ☐ Chiropractic ☐ Massage ☐ Other_________________________________________

Please describe your progress: ☐ Worse ☐ No Change ☐ 25% Better ☐ 50% Better ☐ 75% Better or_______

**Circle** your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other_________________ ___________________

**No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**

In the past week, how much has your pain interfered with your daily activities?

**No Interference** 0 1 2 3 4 5 6 7 8 9 10 **Unable to carry on any activities**

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally

Describe your current health condition: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

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**Please check all of the following that apply to you and list any medication(s) you are taking:**

- ☐ Alcohol/Drug Dependence
- ☐ Abnormal Menstruation
- ☐ Allergies
- ☐ Angina
- ☐ Arthritis/ Rheumatoid Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Breast Lumps
- ☐ Cancer/Tumor
- ☐ Convulsions/Seizures
- ☐ Diabetes
- ☐ Diarrhea/Constipation
- ☐ Excessive Thirst
- ☐ Fainting or Dizziness
- ☐ Fatigue
- ☐ Fever
- ☐ Frequent Urination
- ☐ Headache
- ☐ Heart Attack
- ☐ Heartburn or Indigestion
- ☐ High Blood Pressure
- ☐ Hospitalizations/Surgical Procedures___________________ ___________________________
- ☐ Kidney Disease
- ☐ Liver Problems
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Palpitation/Arrhythmia
- ☐ Peptic Ulcer
- ☐ Pregnant, # Weeks____________
- ☐ Prostate Problems
- ☐ Weight Gain/Loss
- ☐ Sinusitis
- ☐ Stroke
- ☐ Tobacco Use - Type______________ Frequency____________/Day
- ☐ Thyroid Disease
- ☐ Other__________________________ __________________________
- ☐ **Medications**___________________ __________________________

If a family member has had any of the following, please mark the appropriate box and explain the relationship:

- ☐ Cancer______________________
- ☐ Heart Disease__________________
- ☐ Hypertension__________________
- ☐ Lupus________________________
- ☐ Other________________________ __________________________

**Comments**______________________________________________________________________________

I certify that the above information is complete and accurate to the best of my knowledge. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage. I understand that my provider of acupuncture services may need to contact my Primary Care Physician or treating physician if my condition needs to be co-managed. Therefore, I give authorization to my provider of acupuncture services to contact my medical doctor if necessary.

**Patient signature**_________________________________________________________ **Date**___________________

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# PATIENT PROGRESS

**Patient completes this form. Acupuncture**

**Patient Name**________________________________________________________

**Patient, please complete the following questions regarding how you feel today and in the past week.**

**1. How do you feel today?**

**Circle your pain level today.**

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

**In the past week, how often have your symptoms been present?**

☐ Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally ☐ None

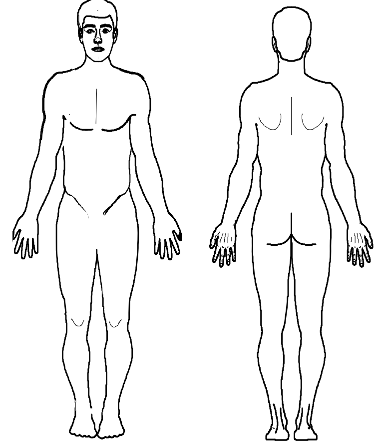
**Circle your average and the worst pain level over the past week.**

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

**Currently, how much has your pain interfered with your daily activities?**

No Interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



**2. Are you getting better?**

| Current Condition(s)/Complaint(s) | Rate your overall progress since starting acupuncture |
|---|---|
| 1____________________ | ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Worse |
| 2____________________ | ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Worse |
| 3____________________ | ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Worse |
| 4____________________ | ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Worse |

**3. Which type(s) of treatment have been helpful to your condition(s)?**

☐ Acupuncture treatment ☐ Nutritional supplements ☐ Rehab Exercise/Home Care
☐ Chinese herbs ☐ Prescription Medication(s) ☐ Spinal Adjustment/Manipulation
☐ Massage therapy ☐ Physical therapy ☐ Other____________________

**4. Is there anything new?**

Have you had any new complaints/conditions? ☐ No ☐ Yes Explain____________________

Have you had any re-injuries or events that have prolonged your recovery? ☐ No ☐ Yes

Explain________________________________________________

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage in the future.

**Patient Signature**____________________________________ **Date**____________________