KOSA Acupuncture

Patient Registration

4 Professional Dr. Suite 115, Gaithersburg, MD 20879

Tel: (301) 801-1028

Patient ☐ Parent ☐ Guardian ☐

Last Name: ______________________________ First Name: ______________________________ MI: _____

Date of Birth: ______________________ (mm/dd/yyyy) Gender: M ☐ F ☐

Address: ____

City: ____ State: _________ Zip: ____________________

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐

Home Phone: ____________________ Cell Phone: ______________________ Work Phone: __________________

Email: ____ Height: ____________ Weight: _____________ lbs

Children (Age & Gender): ____

Primary Physician: _________________ Phone: ________________ Referred by: ________________________

Emergency Contact: ___________________ Phone: _______________ Relationship: ______________________

Insurance Name: ____

Primary Insured ID Number: ____

Insurance Group Number: ____

Primary Insured Name: Last Name: _________________________ First Name: ______________________ MI: ____

Primary Insured Date of Birth: ____________________ (mm/dd/yyyy)

Patient's relationship to Primary Insured: Self ☐ Spouse ☐ Child ☐ Guardian ☐

Health conditions related to work or auto accident? Y ☐ N ☐ If so, Date of Loss:______________ (mm/dd/yyyy)

I. Goals: What would you like to address through treatment?

____

____

II. Medications / Supplements

Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

Allergies (to medications, chemicals or foods):____

III. Lifestyle

1. What is your occupation? _____________________________ How many hours do you work weekly? ______
2. How many servings per day do you use of the following?

   Coffee ____ Tea ____ Soft drinks ____ Alcohol ____ Water ____ Cigarettes, cigars, or other tobacco _____
3. Do you have a known history of any exposure to toxic substances? Yes ☐ No ☐

4. Please describe your current exercise regimen: Hours per week: _____ Activities: ______________________________

5. How many hours of sleep do you usually get per night? _____

   Do you awake feeling rested? Yes ☐ No ☐ Do you sleep soundly? Yes ☐ No ☐

   Do you get up at night to urinate? Yes ☐ No ☐ If so, how often? ________

6. Frequency of bowel movement: _________ per day or _______ per week

   What is the color of stool? ______________________________

For Women:

1. Age: First period ____ Menopause: Yes ☐ No ☐

   a) Average number of days of flow: _______ days The flow is: Normal ☐ Heavy ☐ Light ☐

   c) The color is: Normal ☐ Dark ☐ Purple ☐ Light Brown ☐ Brown ☐

   d) Time between periods: _________ Days

2. Are you pregnant now? Yes ☐ No ☐ Unsure ☐

3. Indicate number of occurrences: Live Births _______ Pregnancies ______

4. Dates: Last Pap Smear_____________ (dd/mm/yyyy) Last Mammogram ___________ (dd/mm/yyyy)

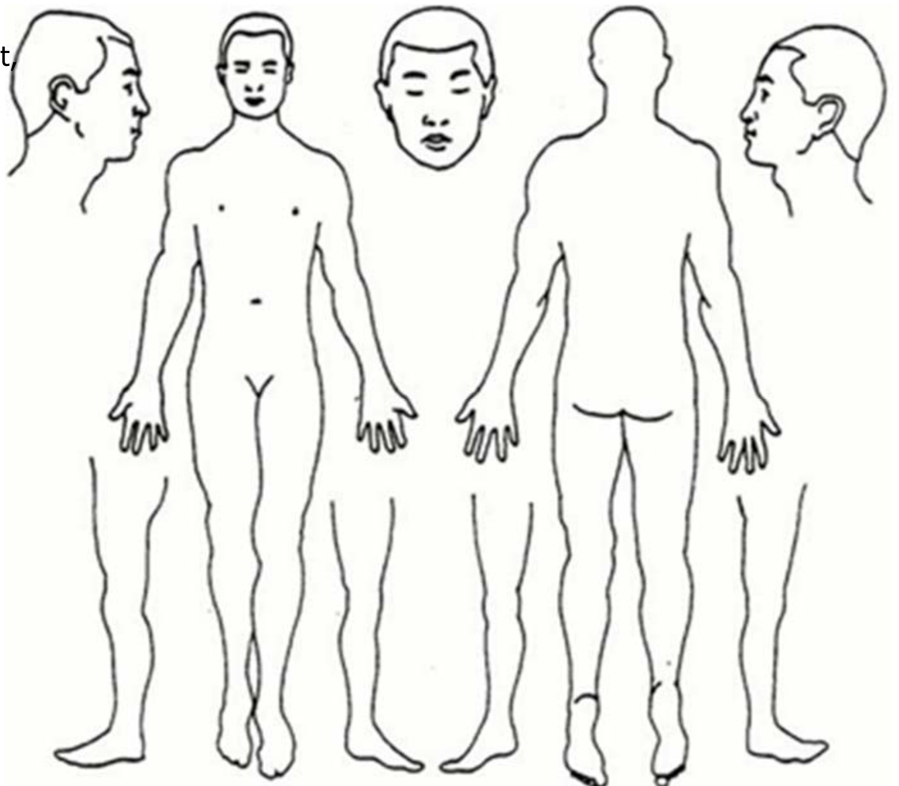
For Men:

Do you have any bothersome urinary, genital, or sexual symptoms? Yes ☐ No ☐

If yes, please describe: ____

IV. Pain

If you are experiencing pain/discomfort, using the models to the right, please indicate the location of the discomfort by using the below symbols that best describes the feeling.



A	Aching
B	Burning
C	Cramps
D	Dull
E	Effusion (Swelling)
N	Numbness
S1	Sharpness
S2	Shooting
S3	Sprain
S4	Stiffness
S5	Strain
T1	Tingling
T2	Throbbing
O	Other

Please describe pains in the order of the severity. **Top priority first, please.** For example, Headache, Neck, Shoulder, Arm, Elbow, Wrist, Hand, Finger, Upper Back, Lower Back, Sciatica, Abdominal, Hip/pelvis, Thigh, Knee, Calf, Foot, Ankle, Toe and etc.

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V. HEALTH: **Please check all that apply, left for past right for current**

Past	Current	Code	Head (Face and Eyes)
		R51	Headache
		G43.111	Migraine with aura
		G43.011	Migraine without aura
		G43.711	Chronic migraine without aura
		G43.911	Migraine, unspecified
		J34.89	Other disease of nasal cavity and sinuses (pain)
		H92.09	Otalgia, unspecified ear (ear pain)
		R68.84	Jaw pain
		Z98.89	Other specified postprocedural states (dental with pain)
			Neck
		M54.2	Cervicalgia (Neck pain)
		M25.50	Pain in unspecified joint (spine, cervical)
		R07.0	Pain in throat
		M50.31	Cervical disc degeneration occipito-atlanto-axial region
		M50.32	Cervical degeneration mid-cervical
		M50.33	Cervical disc degeneration cervicothoracic region
		M47.813	Thoracic spondylosis without myelopathy or radiculopathy cervicothoracic region
		M47.814	Thoracic spondylosis without myelopathy or radiculopathy thoracic region
			Shoulder
		M25.511	Pain in right shoulder
		M25.512	Pain in left shoulder
		M75.51	Bursitis of right shoulder
		M75.52	Bursitis of left shoulder
		M79.601	Pain in right arm
		M79.602	Pain in left arm
		M79.621	Pain in right upper arm
		M79.622	Pain in left upper arm
		M25.611	Stiffness of right shoulder, not elsewhere classified
		M25.612	Stiffness of left shoulder, not elsewhere classified
		M25.419	Effusion (swelling), unspecified shoulder
		M25.411	Effusion (swelling), right shoulder
		M25.412	Effusion (swelling), left shoulder
		S43.50XA	Sprain of unspecified acromioclavicular joint, initial encounter
			Muscle
		M79.1	Myalgia
		M79.7	Fibromyalgia
			Nausea
		R11.0	Nausea
		R11.11	Vomiting without nausea

Past	Current	Code	Thoracic Spine
		M54.6	Pain in thoracic spine
		M20-M25	Pain in unspecified joint (spine, thoracic)
		M47.814	Thoracic spondylosis without myelopathy
		S29.012A	Strain of muscle and tendon of back wall of thorax initial encounter
			Lower Back (lumbosacral)
		M54.5	Low back pain (lumbago)
		M54.41	Lumbago with sciatica, right side
		M54.42	Lumbago with sciatica, left side
		M54.31	Sciatica, right side
		M54.32	Sciatica, left side
		M25.50	Pain in unspecified joint (spine, lumbar or lumbosacral)
		M54.89	Other dorsalgia
		S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter
			Pelvis
		M25.551	Pain in right hip
		M25.552	Pain in left hip
		M25.651	Stiffness of right hip, not elsewhere classified
		M25.652	Stiffness of left hip not elsewhere classified
		M25.451	Effusion (swelling), right hip
		M25.452	Effusion (swelling). Left hip
		S33.8XXS	Sprain of other parts of lumbar spine and pelvis, sequela
			Abdomen
		R10.11	Right upper quadrant pain
		R10.12	Left upper quadrant pain
		R10.31	Right lower quadrant pain
		R10.32	Left lower quadrant pain
		R10.84	Generalized abdominal pain, Abdominal pain, other specified site (multiple sites)
			Arm and Elbow
		M25.521	Pain in right elbow
		M25.522	Pain in left elbow
		M25.531	Pain in right wrist
		M25.532	Pain in left wrist
		M79.631	Pain in right forearm
		M79.632	Pain in left forearm
		M70.21	Olecranon bursitis, right elbow
		M70.22	Olecranon bursitis, left elbow
		M25.421	Effusion (swelling), right elbow
		M25.422	Effusion (swelling)., left elbow
		M25.431	Effusion, right wrist (forearm)
		M25.432	Effusion, left wrist (forearm)
		M25.621	Stiffness of right elbow, not elsewhere classified
		M25.622	Stiffness of left elbow, not elsewhere classified

Past	Current	Code	Wrist and Hand
		M79.641	Pain in right hand
		M79.642	Pain in left hand
		M79.644	Pain in right finger(s)
		M79.645	Pain in left fingers(s)
		M70.11	Bursitis right hand
		M70.12	Bursitis left hand
		M25.631	Stiffness of right wrist, not elsewhere classified
		M25.632	Stiffness of left wrist, not elsewhere classified
			Knee and Thigh
		M25.561	Pain in right knee
		M25.562	Pain in left knee
		M79.651	Pain in right thigh
		M79.652	Pain in left thigh
		M79.661	Pain in right lower leg
		M79.662	Pain in left lower leg
		M70.51	Other bursitis of knee, right knee
		M70.52	Other bursitis of knee, left knee
		M25.461	Effusion (swelling), right knee
		M25.462	Effusion (swelling), left knee
		M25.661	Stiffness of right knee not elsewhere classified
		M25.662	Stiffness of left knee, not elsewhere classified
			Ankle and Foot
		M25.579	Pain in unspecified ankle and joints of right foot
		M25.672	Pain in unspecified ankle and joints of left foot
		M79.671	Pain in right foot
		M79.672	Pain in left foot
		M79.674	Pain in right toe(s)
		M79.675	Pain in left toe(s)
		M25.471	Effusion (swelling), right ankle
		M25.472	Effusion (swelling), left ankle
		M25.474	Effusion (swelling), right foot
		M25.475	Effusion (swelling), left foot
		M25.671	Stiffness of right ankle, not elsewhere classified
		M25.672	Stiffness of left ankle, not elsewhere classified
			Pain - Acute and chronic
		G89.0	Central pain syndrome
		G89.11	Acute pain due to trauma
		G89.21	Chronic pain due to trauma
		G89.29	Other chronic pain
			Respiratory
		R05	Cough
		R07.0	Pain in throat
		J45.20	Intrinsic asthma, unspecified (mild intermittent asthma, uncomplicated)
		J45.991	Cough variant asthma
		J45.998	Other asthma

VI. Recent Hospitalizations / Surgical History

____ Date ____________

____ Date ____________

____ Date ____________

Other relevant information:

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I am receiving acupuncture and related treatments from Byoung Soon Kim L.Ac.

I hereby authorize KOSA Acupuncture to verify information required for processing payment, and to collect payment directly from my insurance.

I understand that if my insurance fails to cover for my treatments or pays me less than the prefixed price (mutually agreed), or pays me directly, I am responsible for making payments. I also authorize the clinic to obtain any medical information on me as needed.

By signing below, I certify that all information I have provided are accurate and to the best of my knowledge.

Client's Name: ____

Client's Signature: ____________________ **Date:** ______________

For Office's Use Only

Treatments: Acupuncture Duration: Hr Min

Office visit (New patient): 99201 ☐ 99202 ☐ 99203 ☐ 99204 ☐ 99205 ☐

Acupuncture w/o Electric 1 SET ☐ 2 SET ☐ 3 SET ☐ 4 SET ☐

Electrical Acupuncture 1 SET ☐ 2 SET ☐ 3 SET ☐ 4 SET ☐

Manual Therapy: (Guasha, Tuina) 15 min ☐ 30 min ☐

Moxa & Cupping: 15 min ☐ 30 min ☐

Massage: 15 min ☐ 30 min ☐

Infrared Heat: 15 min ☐ 30 min ☐

Electrical Stimulation: 15 min ☐ 30 min ☐

Application of Hot or Cold Packs: 15 min ☐ 30 min ☐