

# Pang Acupuncture and Wellness

## Personal Information

Child Name \_\_\_\_\_ Preferred Name (if other) \_\_\_\_\_

Parent/Guardian Name (s) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_

Mobile/Other \_\_\_\_\_ Gender: ☐ F ☐ M ☐ Other: \_\_\_\_\_

Referred by \_\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

## Emergency Contact

Name \_\_\_\_\_ Relation \_\_\_\_\_

Phone Number(s) \_\_\_\_\_

Primary Care Physician's Information:

Physician Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address (City) \_\_\_\_\_

## Medical History

Are you presently being treated for any medical condition? ☐ Yes / ☐ No

What health issue(s) may we help you with? \_\_\_\_\_

Please list below any medicine, supplements, or herbs.

(Include birth control pills, multivitamins, antacids, laxative, diet pills, insulin, etc.)

Drug/Supplement	Amount	Why	How Long?

**\*\*Please turnover and fillout back side of form\*\***

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### *New Patient Form*

Do you have any allergies? (pollen, food, drug) \_\_\_\_\_

Do you have any bleeding/clotting disorders? ☐ Yes / ☐ No

Please list date and type of any surgeries or hospitalizations below.

Date	Hospitalization / Surgery

### **General Lifestyle**

How many glasses of water do you typically drink a day? \_\_\_\_ Tea/Coffee \_\_\_\_ Soda \_\_\_\_

How often do you exercise? \_\_\_\_\_

What type of exercise? \_\_\_\_\_

Would you like to receive periodic informative emails about once a month?

(We will not share your information with anyone)

☐ Yes; please write in email here \_\_\_\_\_ ☐ No Thanks

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Pang Acupuncture and Wellness**  
**Notice of Privacy Practices**

This notice describes how your health information may be used and disclosed and how you may access this information. Please review it carefully. At Pang Acupuncture and Wellness, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use and disclose your health information to those involved in your treatment and in normal healthcare operations. For example, one of our staff may enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or voicemail or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all your health information when required by law. If this practice is sold, your information will become property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request that we not disclose your health information as above. We will let you know if we are able to fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. We will transmit your information for you, for a nominal processing fee.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for your copies. You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment of change, we will not remove or alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Ave, SW, Rm 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our privacy officer, Dorothy Pang at 650.588.0888.

This notice goes into effect as of January 1, 2014.

Acknowledgement: I have received a copy of Dr. Pang's Privacy Practices.

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Signature

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Date

### ***24 hour Cancellation Policy***

By keeping your appointments you ensure that you get the best treatment results while also ensuring that your wait times are kept to a minimum.

For your appointment, we set aside one hour of our time for you. We kindly request that you make every effort to keep your appointment.

If you need to move your appointment time within the same day and there is availability, we will be happy to do so without charge. If you miss an appointment, or there is less than 24 notice for a cancellation, there will be a **\$35** fee.

Thank you for your consideration.

I acknowledge that I have read and agree to the 24 hour cancellation policy.

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Signature

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Date

# NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: \_\_\_\_\_ Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Parent's Phone Number: \_\_\_\_\_

**Directions:** Each rating should be considered in the context of what is appropriate for the age of your child.  
When completing this form, please think about your child's behaviors in the past **6 months**.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

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American Academy  
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

**NICHQ**  
National Institute for  
Children's Health Quality



## NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: \_\_\_\_\_ Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Parent's Phone Number: \_\_\_\_\_

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

**Comments:**

### For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: \_\_\_\_\_

Total number of questions scored 2 or 3 in questions 10–18: \_\_\_\_\_

Total Symptom Score for questions 1–18: \_\_\_\_\_

Total number of questions scored 2 or 3 in questions 19–26: \_\_\_\_\_

Total number of questions scored 2 or 3 in questions 27–40: \_\_\_\_\_

Total number of questions scored 2 or 3 in questions 41–47: \_\_\_\_\_

Total number of questions scored 4 or 5 in questions 48–55: \_\_\_\_\_

Average Performance Score: \_\_\_\_\_

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