FIRST NAME _____ DOB _____ TODAY'S DATE_____

LAST NAME _____ GENDER: M F PHONE #1 _____

EMAIL _____ PHONE #2 _____

ADDRESS_____

OCCUPATION_____ # YEARS WITH CURRENT EMPLOYER_____

PLEASE READ AND INITIAL THE FOLLOWING:

☐ YES ☐ NO Is it alright to leave phone messages containing health related information, such as for filling prescriptions or treatment follow-up?

☐ YES ☐ NO Is it alright to send emails containing content, such as: promotions, discounts or health related newsletters?

Payment is due at time of services rendered unless a PPO, Champus, Medicare, or a Managed Care Program that we bill directly insures you. All deductibles, co-payments, and services not covered by your plan are your responsibility. An annual finance charge of 12%, per California statue, may be charged on all accounts over 60 days past due. There will be a $45 charge on all returned checks. Should collections be necessary, the patient shall pay the Provider, on demand, all costs, including reasonable attorney fees, incurred in collecting payment due under this agreement.

I plan to settle my bill today by circle one: Cash MasterCard Visa Personal Check

I have read and agree to the above payment policy and I understand that I may be charged a cancellation fee of $75 for missed appointments not cancelled without 24 hours notice.

** _____** Initial

SIGN HERE IF YOU HAVE RECEIVED A COPY OF HIPAA NOTICE OF PRIVACY PRACTICES.

_____

Are you new to acupuncture or herbal medicine? ☐ YES ☐ NO

PRIMARY HEALTH CONCERNS:

1. _____

2. _____

SECONDARY HEALTH CONCERNS:

1. _____

2. _____

3. _____

PACEMAKER: Do you now have an artificial pacemaker? (a medical device to regulate heart beat)

☐ YES ☐ NO

CHRONIC DISEASES: Do you now have any chronic (or long term) diseases?

☐ YES ☐ NO Please list: _____

CONTAGIOUS DISEASES: Do you now have any contagious (or infectious) diseases?

☐ YES ☐ NO Please list: _____

BLEEDING DISORDERS: Do you now have any kind of bleeding disorder?

☐ YES ☐ NO Please list: _____

ALLERGIES: Are you now allergic or hypersensitive to any foods, drugs, or medications?

☐ YES ☐ NO Please list: _____

FEMALE PATIENTS ONLY: Are you now pregnant, or could you potentially become pregnant?

☐ YES ☐ NO

DATE: Please list any major health occurrences including: surgeries, hospitalizations, medical studies, etc.

1. _____
2. _____
3. _____
4. _____
5. _____

O = Occasional F = Frequent C = Constant

O F C

Muscle / Joint

- ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ Bursitis
- ☐ ☐ ☐ Foot trouble
- ☐ ☐ ☐ Hernia
- ☐ ☐ ☐ Low back pain
- ☐ ☐ ☐ Lumbago
- ☐ ☐ ☐ Neck pain, stiffness
- ☐ ☐ ☐ Pain between shoulders

General

- ☐ ☐ ☐ Allergy
- ☐ ☐ ☐ Chills
- ☐ ☐ ☐ Convulsions
- ☐ ☐ ☐ Dizziness
- ☐ ☐ ☐ Fainting
- ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ Fever
- ☐ ☐ ☐ Headache
- ☐ ☐ ☐ Loss of sleep
- ☐ ☐ ☐ Loss of weight
- ☐ ☐ ☐ Nervousness, depression
- ☐ ☐ ☐ Neuralgia
- ☐ ☐ ☐ Numbness
- ☐ ☐ ☐ Sweats
- ☐ ☐ ☐ Tremors

Cardiovascular

- ☐ ☐ ☐ Hardening of arteries
- ☐ ☐ ☐ High blood pressure
- ☐ ☐ ☐ Low blood pressure
- ☐ ☐ ☐ Pain over heart
- ☐ ☐ ☐ Poor circulation
- ☐ ☐ ☐ Rapid heartbeat
- ☐ ☐ ☐ Slow heartbeat
- ☐ ☐ ☐ Swelling of ankles

Genitorinary

- ☐ ☐ ☐ Bed-wetting
- ☐ ☐ ☐ Bladder/kidney infection
- ☐ ☐ ☐ Blood in urine
- ☐ ☐ ☐ Frequent urination
- ☐ ☐ ☐ Lack of kidney control
- ☐ ☐ ☐ Painful urination
- ☐ ☐ ☐ Prostate trouble
- ☐ ☐ ☐ Puss in urine
- ☐ ☐ ☐ Low libido
- ☐ ☐ ☐ Sexual dysfunction

O F C

Eye, Ear, Nose & Throat

- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Colds
- ☐ ☐ ☐ Crossed eyes
- ☐ ☐ ☐ Deafness
- ☐ ☐ ☐ Dental decay
- ☐ ☐ ☐ Earache
- ☐ ☐ ☐ Ear discharge
- ☐ ☐ ☐ Ear noise
- ☐ ☐ ☐ Enlarged glands
- ☐ ☐ ☐ Enlarged thryoid
- ☐ ☐ ☐ Eye pain
- ☐ ☐ ☐ Failing vision
- ☐ ☐ ☐ Far sightedness
- ☐ ☐ ☐ Gum trouble
- ☐ ☐ ☐ Hay fever
- ☐ ☐ ☐ Hoarseness
- ☐ ☐ ☐ Nasal obstruction
- ☐ ☐ ☐ Near sightedness
- ☐ ☐ ☐ Nose bleeds
- ☐ ☐ ☐ Sinus infection
- ☐ ☐ ☐ Sore throat
- ☐ ☐ ☐ Tonsillitis

Gastrointestinal

- ☐ ☐ ☐ Acid reflux/heartburn
- ☐ ☐ ☐ Belching or gas
- ☐ ☐ ☐ Colitis
- ☐ ☐ ☐ Colon trouble
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Difficult digestion
- ☐ ☐ ☐ Bloated abdomen
- ☐ ☐ ☐ Excessive hunger
- ☐ ☐ ☐ Gallbladder trouble
- ☐ ☐ ☐ Hemorrhoids
- ☐ ☐ ☐ Intestinal worms
- ☐ ☐ ☐ Jaundice
- ☐ ☐ ☐ Liver trouble
- ☐ ☐ ☐ Nausea
- ☐ ☐ ☐ Pain over stomach
- ☐ ☐ ☐ Poor appetite
- ☐ ☐ ☐ Vomiting
- ☐ ☐ ☐ Vomiting of blood

O F C

Skin

- ☐ ☐ ☐ Boils
- ☐ ☐ ☐ Bruise easily
- ☐ ☐ ☐ Dryness
- ☐ ☐ ☐ Eczema/psoriasis
- ☐ ☐ ☐ Hives or allergy
- ☐ ☐ ☐ Itching
- ☐ ☐ ☐ Skin eruptions (rash)
- ☐ ☐ ☐ Varicose veins

Pain or Numbness in

- ☐ ☐ ☐ Shoulders
- ☐ ☐ ☐ Arms
- ☐ ☐ ☐ Elbows
- ☐ ☐ ☐ Hands
- ☐ ☐ ☐ Hips
- ☐ ☐ ☐ Legs
- ☐ ☐ ☐ Knees
- ☐ ☐ ☐ Feet
- ☐ ☐ ☐ Painful tailbone
- ☐ ☐ ☐ Poor posture
- ☐ ☐ ☐ Sciatica
- ☐ ☐ ☐ Spinal curvature
- ☐ ☐ ☐ Swollen joints

Respiratory

- ☐ ☐ ☐ Chest pain
- ☐ ☐ ☐ Chronic cough
- ☐ ☐ ☐ Difficulty breathing
- ☐ ☐ ☐ Spitting up blood
- ☐ ☐ ☐ Spitting up phlegm

Women Only

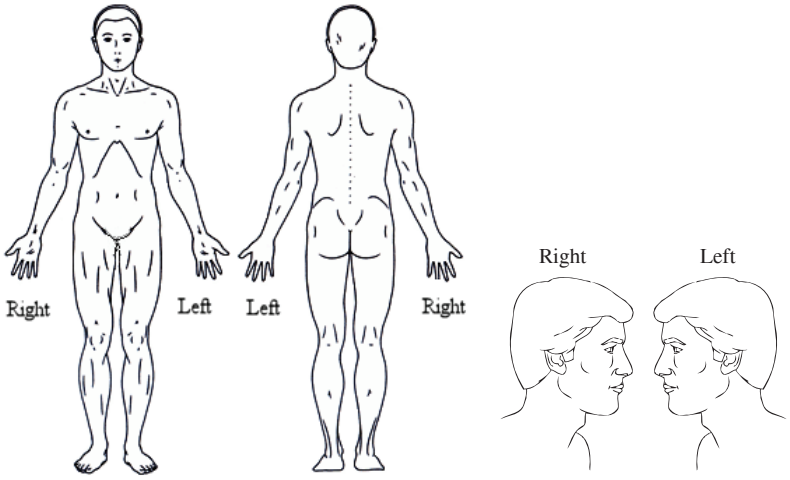
- ☐ ☐ ☐ Congested breasts
- ☐ ☐ ☐ Cramps or backache
- ☐ ☐ ☐ Excess menstrual flow
- ☐ ☐ ☐ Hot flashes
- ☐ ☐ ☐ Irregular cycle
- ☐ ☐ ☐ Lumps in breast
- ☐ ☐ ☐ Menopause
- ☐ ☐ ☐ Painful menstruation
- ☐ ☐ ☐ Vaginal discharge

Are you pregnant? ☐ Yes ☐ No
If yes, how many months? _____
How many children do you have? _____

Check any of the following conditions you current have or have had:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cholera
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diptheria
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ High cholesterol
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

Please indicate any areas of body pain, stiffness or numbness.



Please list all your medications including pharmaceutical drugs, herbs, vitamins, minerals or other supplements.

MEDICATION	DOSE	MEDICATION	DOSE
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

HABITS:	None	Light	Mod	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

Please check any you are interested in:

- ☐ Acupuncture
- ☐ Manual Therapy including: massage, cupping, etc.
- ☐ Diet & Lifestyle Changes
- ☐ Nutritional Supplements & Herbs

THANK YOU.

Signature of patient or legal Representative: _____

Date: _____