

Patient Health History & Intake Form

Name _____ birthdate _____ age _____

Address (street, city, state, zip) _____

Contact number _____ email _____

Who referred you? yelp google groupon friend _____ other _____

Insurance company name _____ phone# _____ ID# _____

Full Address (found on card) _____ PPO HMO POS

1. What are your reasons for this visit? a. _____ b. _____ c. _____

2. How long has it been going on? _____ 3. Were you under stress? yes no not sure

4. What makes it feel better? (check all that apply)

- cold warmth massage lying down standing up
 rest activity quiet nothing other _____

5. What makes it feel worse? (check all that apply)

- cold warmth massage lying down standing up
 rest activity stress nothing other _____

6. Do you feel your condition is getting progressively worse? yes no not sure

7. Does your condition interfere with your daily routine? yes no sometimes

8. What kind of diet do you have? vegan vegetarian omnivore RAW
 gluten free low carb dairy free other _____

9. On average, how many hours of sleep do you get each night? _____

10. Do you have trouble falling asleep? yes no sometimes

11. Do you wake up during the night? yes no sometimes

• If so, how many times do you wake up? _____

12. How do you feel when you wake up in the morning? tired well rested other _____

13. Do you dream at night? If so, what are they like? don't remember vivid and real don't make sense

14. On a scale of 1 - 10 please rate your energy level. _____

15. On a scale of 1 - 10, please rate the amount of pain you are in. _____

16. Where is your pain located? (check all that apply)

- head eyes ears neck shoulders upper back
 chest abdomen mid back low back groin hips feet
 arms wrists elbows hands legs knees other

17. Please describe the "quality" of the pain. (check all that apply)

- stiff achy sharp stabbing shooting radiating
 dull burning tingling numb other _____

18. What time of day do you feel the pain the most?

- morning daytime evening all the time wakes me up at night other _____

19. Does the pain get worse when you get emotionally upset? yes no sometimes not sure

20. Have you noticed any unusual or unexplained sweating? (check all that apply)

- nighttime spontaneous profuse daytime other _____

21. Eyes, Ears, Nose, Throat, Respiratory

- asthma wheezing allergies SOB frequent colds/flu blurry vision
 hearing loss ringing in ears persistent cough sinus congestion
 red eyes dry eyes watery eyes eye twitches floaters respiratory infection

22. Skin

- boils dry itchy oily sensitive sweaty eczema
 psoriasis acne shingles rashes hives non healing sores

23. Genito/Urinary

- frequent urination scanty urination incontinence painful urination burning urination
 cloudy urine dark urine UTI kidney stones kidney infection
 enlarged prostate blood in urine urgency to urinate other _____

24. Cardiovascular

- chest pain blood clots palpitations irregular heart beat poor circulation
 swollen ankles dizziness anemia heart attack varicose/spider veins
 high blood pressure low blood pressure other _____

25. Digestive

- nausea/vomiting belching gas bloating hiccups hemorrhoids
 loose stool diarrhea constipation blood in stool pus in stool
 excessive hunger poor appetite epigastric pain indigestion
 gall stones Crohn's disease IBS ulcerative colitis

26. Psychological

- depression stress grief anxiety
 anger worry nervous irritability
 overwhelmed timid or shy fear frustration
 paranoia abuse trouble focusing other _____

27. Neurological

- paralysis seizures tremors numbness/tingling
 nerve pain facial paralysis MS Parkinson's Disease
 difficulty swallowing other _____

28. Infectious disease

- HIV TB hepatitis herpes simplex gonorrhea
 chlamydia syphilis HPV MRSA genital warts other _____

29. Medication/Supplements

- aspirin ibuprofen tylenol blood thinners antacids tranquilizers
 laxative insulin anti-anxiety anti-depressants oral contraceptives
 blood pressure vitamins omega 3 probiotics herbs
 sleeping pills other _____

30. Body temperature

- cold: I like to bundle up warm: I get hot easily neutral
 cold hands/feet hot hands/feet other _____

Women only

31. Date of the first day of your last menstruation ____ / ____ / ____

32. Reproductive History.

- painful periods heavy period scanty period abnormal bleeding
 irregular cycle regular cycle on the pills bleeding between periods
 vaginal infection PCOS abnormal pap clots in menstrual blood
 breast lumps breast cancer PID cervical dysplasia
 PMS menopause currently pregnant painful/itching genitalia
 HPV lack of period longer then 6 months not due to pregnancy or menopause

33. PMS Do you experience any of these symptoms right before your period?

- bloating breast distention headache irritability crying
 anger dizziness frustration back pain emotional
 pelvic pain fatigue insomnia other _____

***You MUST inform the acupuncturist if you are or plan on becoming pregnant during the course of the treatment.**

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible for) by Dawna Ara, who is a Licensed Acupuncturist in the state of California, and or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for Dawna Ara, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is generally a safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I have been informed the side effects of acupuncture facial rejuvenation include bruising on the face, redness on the face, and/or bleeding on the face. I understand the contradictions of facial acupuncture include high blood pressure, dizziness, diabetes, pregnancy, facial sunburn, asthma, those who have had recent botox or restalyn injection, microdermabrasion, chemical peel, acute herpes outbreak on the face, have a cold/flu, pituitary tumors or cushing's disease, hemophiliacs, those on blood thinners, taking aspirin, vitamin E, and/or fish oil, those prone to migraines, epilepsy or seizures, lymphoderma in the face, cancer, AIDS, or coronary diseases. If I have any of these above conditions I will inform the acupuncturist before starting treatment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of the treatment, and I wish to rely o the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand the results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present conditions and for any future conditions for which I seek treatment.

Please print patient's name _____

Patient Signature _____ date _____

FINANCIAL AGREEMENT, INSURANCE POLICY, & CANCELLATION POLICY

Financial Agreement

Payment is due at the time of service. For your convenience we accept cash, check, and all major credit cards.

Insurance Policy

Some insurance companies cover acupuncture services. We will gladly check to see if your plan includes acupuncture. When using insurance, you are responsible for your co-pay, deductible, and non covered or excluded amounts under your policy. When using insurance you must pay full rates and may not use coupons or special rates.

Cancellation Policy

We have a 24 hour cancellation policy. We ask that if you would like to cancel that you give us at least 24 hours notification before the scheduled appointment. If a 24 hour notice is not given, you may be charged \$30 for the missed appointment. If you purchased agroupon coupon and miss your appointment then you will forfeit the coupon.

I have read and understand the the financial agreement, insurance, and cancellation policy. I understand that all services that I have are my financial responsibility and due at the time of service.

Patient Signature _____ date _____