

## PATIENT INFORMATION

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Referred By: \_\_\_\_\_  
In Case of Emergency: \_\_\_\_\_

Will we be billing insurance? \_\_\_\_\_

If yes, please provide the following information:

Name of Spouse/Responsible Party: \_\_\_\_\_  
Spouse/Responsible Party's Employer: \_\_\_\_\_  
Spouse/Responsible Party's SSN: \_\_\_\_\_  
Primary: \_\_\_\_\_ Group/Plan No. \_\_\_\_\_  
Secondary: \_\_\_\_\_ Group/Plan No. \_\_\_\_\_

### OFFICE POLICY:

Our office policy has been established to assure that the best health service can be provided to you and your family.

Payment is due when services are rendered. You may pay by check, cash or Visa and Mastercard. The doctor's services are rendered to you not to your insurance company. If you have insurance, we will do our best to determine what dollar amount you are responsible for via telephone verification. We will submit and process your insurance claims and accept the partial payment until insurance payments are received. Some insurance companies send payments directly to the patient and in this case, we ask that you pay for services in full at the time of service. Please keep in mind the amount quoted over the telephone may or may not be accurate and you are ultimately responsible for payment for services rendered. We offer a cash discount to patients who pay at the time of service or prepay for a treatment plan. No discount will be given to patients we must bill. All patients will be

expected to pay in full for all services until your deductible has been met. If a payment schedule is necessary, arrangements must be made with the doctor providing service, prior to treatment. This will avoid any misunderstanding and enable you to keep your account in good standing. All accounts over 60 days past due will be subject to a monthly billing charge. There is a sur-charge on all returned checks.

For cancellation of appointments, we require that 24-hours notice is given. On less than 24-hours notice, you will be subject to a \$45.00 late cancellation fee. For patients 15-30 minutes late you may be asked to reschedule your appointment or have a shortened session.

I, the undersigned, agree to be solely and severally responsible for payment of all services rendered to myself and/or any member of my family. I certify that I have read and understand completely the office policy set forth and I agree to its stipulations. My signature below is my consent to be examined and treated and if this office is submitting claims for insurance benefits, that these benefits are assigned to my doctor for the services that he/she provides

\_\_\_\_\_ Date: \_\_\_\_\_

# COMPREHENSIVE ACUPUNCTURE EXAMINATION

*NOTE: This is a confidential record of your medical history and will be kept in this office.  
Information contained here will not be released to any person without your authorization.*

NAME \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ Account No. \_\_\_\_\_

Birth Date: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Major Complaint/s \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Complaints: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of onset (when you first noticed your problem)? \_\_\_\_\_

Pain is:  Minimal  Slight  Moderate  Severe

How long have you had this condition? \_\_\_\_\_

Have you had this in the past?  Yes  No When? \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Is your condition:  Getting worse  Constant  Comes and Goes

Medications/Drugs/Herbs you are currently taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Surgeries/Operations you have had and dates: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of your last physical examination \_\_\_\_\_ By whom? \_\_\_\_\_

**MEDICAL HISTORY:** (Do you have or have you ever had):  Arthritis  Asthma  Anemia  Heart trouble  Cancer

Diabetes  Epilepsy  Stroke  Kidney or bladder trouble  Gallstones  Ulcers  High blood pressure

Chronic fatigue  Hepatitis  Jaundice  Sudden weight loss  Sudden weight gain

Other: \_\_\_\_\_

**FAMILY HISTORY:** (Has any member of your family had any of the above)?  Yes  No If yes, which member and what did they have? \_\_\_\_\_  
\_\_\_\_\_

**ENERGY LEVEL:**  High (Time of day) \_\_\_\_\_  Low (Time of day) \_\_\_\_\_

**STRESS:**  None  Moderate  Severe What causes it? \_\_\_\_\_

**SWEATING:**  Night sweats  Rarely sweat  Excess sweating \_\_\_\_\_

**CIRCULATION:** Feelings of  Hot  Cold What area? \_\_\_\_\_

Bleed easily  Cold limbs Other: \_\_\_\_\_

**SKIN:**  Dry  Itchy  Moist/clammy  Burning  Changing moles or lumps (cysts/tumors)  Boils

Frequent skin rashes  Acne  Hair loss/thinning  Dry scalp  Skin puffy/wrinkled

Bruises easily (black and blue spots)  Hives Other: \_\_\_\_\_

**SCARS:** (List ALL scars from accidents or surgeries) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SLEEP PROBLEMS:**  Trouble falling asleep  Trouble staying asleep  Restful  Excess dreaming

Other: \_\_\_\_\_ How many hours do you sleep a night? \_\_\_\_\_

**HEAD:**  Headaches (what area?) \_\_\_\_\_  Dizziness  Memory loss  Loss of balance

Other: \_\_\_\_\_

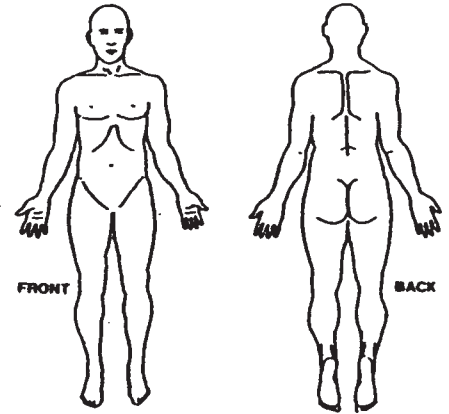
**EYES:**  Eye pain  Dry eyes  Blurred vision  Darkness under eyes Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EARS:**  Poor hearing  Earaches  Ear discharge/infections  Ringing/buzzing in ears

Other: \_\_\_\_\_

**NOSE:**  Frequent nose bleeds  Sinus trouble  Frequent colds Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE MARK YOUR AREAS OF PAIN



**THROAT:**  Sore throat  Hoarseness  Difficulty swallowing  Jaw problems  Teeth/gum problems  Swollen tongue

Other: \_\_\_\_\_

**CHEST:**  Hard to breathe  Wheezing  Shortness of breath  Mucus rattles when breathing  Trouble breathing at night

Pain/pressure in chest  Palpitations  Persistent cough  Coughing blood  Coughing phlegm

Sputum color \_\_\_\_\_ Consistency \_\_\_\_\_

Other: \_\_\_\_\_

**BLOOD PRESSURE:**  High  Low  Do not know

**BOWELS:**  Diarrhea  Constipation  Bloody stools  Black stools  Mucus in stools  Hemorrhoids

Lower bowel gas  Stools have foul odor  Colon problems  Number of bowel movements a day \_\_\_\_\_

Other: \_\_\_\_\_

**URINE:** Color \_\_\_\_\_ Amount \_\_\_\_\_ Frequent urination  Daytime  At night

Strong smelling urine  Hard to urinate  Pain or burning on urinating  Blood in urine

Frequent infections  Water retention Other: \_\_\_\_\_

**MUSCULOSKELETAL:** Pain in:  Neck  Shoulder  Between shoulders  Arms/hands  Hip  Knee

Fingers  Big toe  Upper back  Mid back  Lower back  Bones sore/painful  Loss of grip

Swollen knees/elbows  Leg cramps at night  Weakness in legs  Weak ankles  Stiff all over

Tingling in feet  Muscle spasm/cramps  Loss of feeling in hands/feet  Painful joints  Bursitis

Other: \_\_\_\_\_

**NEUROLOGICAL:**  Nervousness  Depressed  Easily angered  Easily irritated  Frequent crying

Worry/Anxiety  Mood swings  Memory confusion  Poor concentration  Suicidal  Tremors

Numbness/tingling in limbs  Poor coordination  Muscle weakness  Feel weak and shaky  Seizures

Neuralgia (nerve pain)  Shingles Other: \_\_\_\_\_

**FEMALES:**  Pregnant?  yes  No Last monthly period \_\_\_\_\_ Last PAP test \_\_\_\_\_

Form of birth control:  None  Pill Other: \_\_\_\_\_

Age started menstrual cycle \_\_\_\_\_ Age stopped \_\_\_\_\_  Menstrual pain  Low backache

Irregular  Clotting  Heavy bleeding  Light scanty bleeding  Color \_\_\_\_\_

Water retention  Mood changes  Miss periods  Low or no sex drive  Painful breasts  Hot flashes

Food cravings Other: \_\_\_\_\_

Discharges:  Yellow  Thick  White  Odor  Itching  Liquid Other: \_\_\_\_\_

No. Pregnancies \_\_\_\_\_ No. Deliveries \_\_\_\_\_ No. Miscarriages \_\_\_\_\_ No. Abortions \_\_\_\_\_

No. Cesareans \_\_\_\_\_ Operations:  Cervix  Uterus  Ovaries Other: \_\_\_\_\_

**MALES:**  Low sexual drive  Lack of sexual drive  Impotence  Ejaculation causes pain  Discharges

Pain or burning while urinating  Premature ejaculation  Prostate trouble Other: \_\_\_\_\_

**APPETITE:**  Excessive appetite  Poor appetite  Appetite keeps changing  Feel tired or weak if a meal is missed

Excessive thirst  Never thirsty Other: \_\_\_\_\_

Specific food cravings?  Yes  No If yes, what? \_\_\_\_\_

Other: \_\_\_\_\_

**DIGESTION:**  Stomach gas  Lower bowel gas  Heartburn  Burning/belching  Stomach pain

Stomach cramps  Nausea  Vomiting  Bad breath  Sores in mouth  Weight gain  Weight loss

Bitter/sour taste in mouth  Abdominal bloating How long after eating? \_\_\_\_\_

Food allergies?  yes  No If yes, to what? \_\_\_\_\_

**NUTRITION:** List some of your favorite foods \_\_\_\_\_

Do you:  Skip breakfast  Eat a snack  Eat a hearty breakfast

How many meals a day do you eat? \_\_\_\_\_ When is your biggest meal? \_\_\_\_\_

Do you eat when you are worried or rushed?  Yes  No How often? \_\_\_\_\_

Do you plan your meals according to the "Four basic food groups"?  Yes  No

How many glasses of water do you drink a day? \_\_\_\_\_  Filtered  Bottled

Do you use: Alcohol?  Yes  No Amount per week \_\_\_\_\_ Type \_\_\_\_\_  
 Tobacco?  Yes  No Packs per day \_\_\_\_\_ How many years \_\_\_\_\_

**DO YOU:**

Eat raw fruits or vegetables at least twice a day?  Yes  No  
 Eat green or yellow vegetables at least twice a day?  Yes  No  
 Eat frequently between meals?  Yes  No  
 Chew your food thoroughly before swallowing it?  Yes  No  
 Drink juice, milk or other drinks instead of water when thirsty?  Yes  No  
 Always add salt at the table?  Yes  No

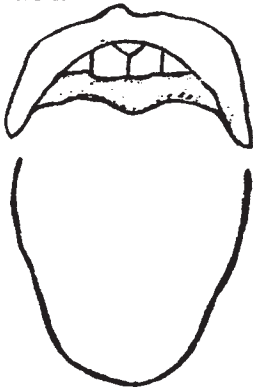
Eat meat or dairy products 2 or more times a day?  Yes  No  
 Eat the same foods almost every day?  Yes  No  
 Eat when you are not hungry?  Yes  No  
 Eat until you feel full?  Yes  No  
 Occasionally go on a "crash" diet?  Yes  No

Patient's Signature \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

**EXAMINATION**

**TONGUE:**



Color \_\_\_\_\_

\_\_\_\_\_

Coat \_\_\_\_\_

\_\_\_\_\_

Body \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PULSE**

**RIGHT**

**LEFT**

**GENERAL CHARACTER**

TEMPERATURE: \_\_\_\_\_

BLOOD PRESSURE: \_\_\_\_\_

**APPEARANCE:**  Excellent  Good  Fair  Well-nourished  Undernourished  Debilitated  Thin  
 Husky  Overweight \_\_\_\_\_

**MOVEMENT:**  Guarded  Slow  Impaired  Needs assistance  Deformity \_\_\_\_\_

**SKIN COLOR:** \_\_\_\_\_ **FACIAL COLOR:** \_\_\_\_\_ **EYES:** \_\_\_\_\_

**AREA CLIMATE:** Body odors \_\_\_\_\_ Smell \_\_\_\_\_

**ABDOMEN (by palpation):**  Organ swelling  Masses  Hernia  Pain \_\_\_\_\_

**ABDOMINAL REFLEX(es):** \_\_\_\_\_

**ASSESSMENT/EVALUATION/FINDINGS:** (Internal, emotional, dietary, channel disorders, trauma, constitution, inactivity, overworked, etc.)

**EIGHT PRINCIPLES:** (Yin/Yang, Internal/External, Hot/Cold, Deficient/Excess) \_\_\_\_\_

