

PATIENT INFORMATION

Name:	Date of Birth:
Address:	Social Security #:
City:	Sex:
State: Zip:	Employer:
Home Phone #:	Emergency Contact:
Work Phone #:	Emergency Phone #:
Cell Phone #:	Emergency Relationship:
Email Address:	

GUARANTOR INFORMATION

Name:	Date of Birth:
Address:	Social Security #:
City:	Employer:
State: Zip:	Employer Address:
Home Phone #:	Employer City:
Work Phone #:	Employer State:
Cell Phone #:	Zip:

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Certificate #:	Certificate #:
Group Number:	Group Number:
Group Name:	Group Name:
Copay:	Copay:
Subscriber Name:	Subscriber Name:

ADDITIONAL INFORMATION

Primary Care Physician:	Pharmacy Name:
Phone:	Phone:
Fax:	Fax:
Address:	Address:
City:	City:
State: Zip:	State: Zip:

Complete information below, if applicable:

Attorney Name:	Adjuster Name:
Phone:	Phone:
Address:	Fax:
City/State/Zip:	Date of Injury:

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or Pain Care Acupuncture Clinic when they accept assignment.

Authorization to Release Medical Information: I hereby authorize Pain Care Acupuncture Clinic to release any information necessary for my course of treatment.

ADDITIONAL INSURANCE QUESTIONS

- Is the subscriber currently employed and working? YES / NO
If yes, does the company have more than 20 employees? YES / NO
- Is the subscriber out on disability? YES / NO
If yes, does company have greater than 100 employees? YES / NO
- Is this a Cobra policy? YES / NO

Signature (Patient or Personal Representative)

Date

HEALTH HISTORY QUESTIONNAIRE

Information for your Acupuncturist

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.
All information is strictly confidential.

I. Major Complaints:

Major Complaint(s), in order of significance to you:

- | | |
|----------|-------------------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | Additional: _____ |

How do these conditions impair your daily activities? _____

II. Patient Medical History

How was your childhood health? _____

Hospital Visits/Stays: _____

Recent tests: (please indicate test results and date below)

- | | | | |
|-----------------------------------|--------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Physical | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Prostate | <input type="checkbox"/> Blood (which?) |
| <input type="checkbox"/> HIV/STD | <input type="checkbox"/> Pap smear | <input type="checkbox"/> Mammography | <input type="checkbox"/> Other: _____ |

Test Results and Date: _____

Check any you have had in the past:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> Vein condition | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Bleeding tendency |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Nervous disorder |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Polio | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High fever | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraines | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> other lung illnesses | <input type="checkbox"/> other liver illnesses | <input type="checkbox"/> other heart illnesses | <input type="checkbox"/> other kidney illnesses |

other: _____

Immunizations: _____

Surgeries: _____

III. Patient Profile

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):

Is the pain:

Sharp Burning Aching Cramping Dull Moving Fixed

Other:_____

Do the following lessen the pain?

Pressure Cold Heat Exercise

Other:_____

Do the following worsen the pain?

Pressure Cold Heat Other:_____

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function):

Overall Temperature (Kidney function):

- Cold hands
- Cold fingers
- Cold feet
- Cold toes
- Sweaty hands
- Sweaty feet
- Hot body temperature (sensation)
- Cold body temperature (sensation)
- Afternoon flushes
- Night sweats
- Heat in the hands, feet, and chest
- Hot flashes any time of the day
- Thirsty
- Perspire easily
- Lack of perspiration
- Take water to bed
- Take water to bed
- Others_____

Overall energy (Lung, Kidney function):

- Shortness of breath
- Difficulty keeping eyes open in the daytime
- General weakness
- Easily catch colds
- Low energy
- Feel worse after exercise
- Others_____

Overall blood (Liver, Spleen, Heart function):

- Dizziness
 - See floating black spots
 - Others _____
-

Heart function:

- Palpitations
 - Anxiety
 - Sores on the tip of the tongue
 - Restlessness
 - Mental confusion
 - Chest pain traveling to shoulder
 - Frequent dreams
 - Wake unrefreshed
 - Drink coffee (# of cups per week: _____)
 - Others _____
-

Lung function:

- Nasal Discharge (Color: _____)
 - Cough
 - Nose Bleeds
 - Sinus Congestion
 - Dry mouth
 - Dry throat
 - Dry Nose
 - Dry Skin
 - Allergies (To what? _____)
 - Alternating fever and chills
 - Sneezing
 - Headache (Location: _____)
 - Overall achy feeling in the body
 - Stiff neck
 - Stiff shoulders
 - Sore throat
 - Difficulty breathing
 - Smoke cigarettes (# of cigarettes per day: _____)
 - Sadness
 - Melancholy
 - Others _____
-

Spleen function:

- Low appetite
- Abrupt weight gain
- Abrupt weight loss
- Abdominal bloating
- Abdominal gas
- Gurgling noise in the stomach
- Fatigue after eating
- Prolapsed organs (previously diagnosed, which organ? _____)

- Easily bruised
- Hemorrhoids
- Pensive
- Over-thinking
- Worry
- Others _____

Spleen, Stomach, Large Intestine, Small Intestine function:

- Loose
- Constipated
- Incomplete
- Diarrhea
- Blood in stools
- Mucous in stools
- Undigested food in stools
- Others _____

Dampness trapped in the body:

- General sensation of heaviness in the body
- Mental heaviness
- Mental sluggishness
- Mental fogginess
- Swollen hands
- Swollen feet
- Swollen joints
- Chest congestion
- Nausea
- Snoring
- Others _____

Stomach function:

- Burning sensation after eating
- Large appetite
- Bad breath
- Mouth (canker) sores
- Bleeding, swollen or painful gums
- Heartburn
- Acid regurgitation
- Ulcer (diagnosed)
- Belching
- Hiccoughs
- Stomach pain
- Vomiting
- Others _____

Liver, Gall Bladder function:

- Alternating diarrhea and constipation
- Chest pain
- Tight sensation in the chest

- Bitter taste in the mouth
- Anger easily
- Frustration
- Depression
- Irritability
- Frequently unable to adapt to stress (What causes the stress? _____)
- Skin rashes
- Headache at the top of the head
- Tingling sensation
- Numbness
- Muscle spasms
- Muscle twitching
- Muscle cramping
- Seizures
- Convulsions
- Lump in the throat
- Neck tension
- Limited Range-of-Motion, Neck
- Shoulder tension
- Limited Range-of-Motion, Shoulder
- Drink alcohol
- Recreational drugs (Which? _____, How much per week? _____)
- High-pitched ringing in the ears
- Gall stones (history or current)
- Sexually transmitted disease (Which? _____)
- Others _____

Eyes (Liver function):

- Itchy
- Bloodshot
- Hot
- Dry
- Watery
- Gritty
- Blurry vision
- Decreased night vision
- Near-sighted
- Far-sighted
- Others _____

Kidney, Urinary Bladder function:

- Frequent cavities
- Easily broken bones
- Sore knees
- Weak knees
- Cold sensation in the knees
- Low back pain
- Memory problems
- Excessive hair loss
- Low-pitched ringing in the ears
- Kidney stones

- Bladder infections
- Wake during the night twice or more to urinate
- Lack of bladder control
- Fear
- Easily startled
- Others_____

Urination:

- Normal color
- Dark yellow
- Clear
- Reddish
- Cloudy
- Scanty
- Profuse
- Strong odor
- Burning
- Painful
- Discharge
- Difficult
- Painful
- Urgent
- Frequent
- Others_____

Libido:

- Normal
- High
- Low

Women only:

- | | |
|--|---|
| Regular menstrual cycle? <input type="checkbox"/> Y <input type="checkbox"/> N | Pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N |
| Number of children:_____ | Number of pregnancies:_____ |
| Age of first menstruation:_____ | Age of menopause (if applicable):_____ |
| Average number of days of flow:_____ | Average number of days of entire cycle:_____ |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Bleeding between periods |
| <input type="checkbox"/> Others_____ | |

Do you experience any of the following pre-menstrual syndromes?

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> nausea | <input type="checkbox"/> vomiting | <input type="checkbox"/> water retention | <input type="checkbox"/> breast swelling |
| <input type="checkbox"/> food cravings | <input type="checkbox"/> headaches | <input type="checkbox"/> migraines | <input type="checkbox"/> breast tenderness |
| <input type="checkbox"/> depression | <input type="checkbox"/> irritability | <input type="checkbox"/> anxiety | <input type="checkbox"/> other emotions:_____ |
| <input type="checkbox"/> dull pain, where?_____ | <input type="checkbox"/> sharp pain, where?_____ | | |
| <input type="checkbox"/> Others_____ | | | |

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Men only:

- Swollen testes
 Testicular pain
 Impotence
 Premature ejaculation
 Feeling of coldness or numbness in external genitalia
 Other _____

All please fill out:

Other Comments: _____

Patient Signature: _____

Acupuncturist Signature: _____