Family Chiropractic & Acupuncture Center

2801 Waterman Blvd. Ste. 260
Fairfield, CA 94534

PATIENT CONFIDENTIAL INFORMATION

Name: ____
First Middle Last

Address: ____
Street City State Zip

Social Security #: ______________________

Home #: ______________________ Cell #: ______________________

E-mail: ______________________ Work #: ______________________

Employer: ______________________ Occupation: ______________________

In case of emergency, call:

Name: ______________________________

Phone #: ______________________________

FOR MINORS: List both parent's name and address:

NEW PATIENT HISTORY

Date of Birth: Age: Gender: M / F Height: Weight:

-Are you 18 years or older? Y / N If 'NO' parent must sign for consent here: ______________________

-I understand that bleeding or bruising is a possible side effect of acupuncture Y / N

-Do you have any bleeding disorder? Y / N

-Are you taking any blood thinners? (Coumadin, Heparin, Aspirin, or other) Y / N

-Is your immune system comprised by cold, flu, diabetes or autoimmune disease? Y / N

1. When and where did you last receive health care?

   For what reason?

2. Please identify the health concerns that have brought you to our office, **in order of importance:**

Condition	**Date of Onset**	**Past Treatment**
a. ______________	______________	______________
b. ______________	______________	______________
c. ______________	______________	______________
d. ______________	______________	______________

3. Please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

4. Please list any medications (prescribed or over-the-counter), vitamins, and supplements you are currently taking:

5. Do you have any reason to believe you may be pregnant? Y / N If so, how along are you? ________

6. Do you have any infectious diseases? Y / N If yes, please identify:

8. Hospitalizations and Surgeries:

Reason	**When**	**Reason**	**When**

9. Family History: (check if applicable)

	Father	**Mother**	**Brothers**	**Sisters**	**Spouse**	**Children**
Cancer	______	______	______	______	______	______
Diabetes	______	______	______	______	______	______
Heart Disease	______	______	______	______	______	______
High Blood Pressure	______	______	______	______	______	______
Stroke	______	______	______	______	______	______
Mental Illness	______	______	______	______	______	______
Asthma	______	______	______	______	______	______
Kidney Disease	______	______	______	______	______	______

10. Childhood Illness: (if you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles Chicken Pox

DIRECTIONS: if you experience now and underline <u>if have experienced in the past.</u>

11. Overwhelming Emotions

Mood Swings Nervousness Mental Tension Anger Frustration Irritability Sadness Other:

Please Note*: Emotional systems help with Traditional Chinese Medicine pattern diagnosis and point determination. Family chiropractic and Acupuncture Center does not provide counseling service.*

12. Energy and Immunity

Fatigue Slow Wound Healing Chronic Infection Frequent Cold/Flu Seasonal Allergies

13. Head, Eye, Ear, Nose, and Throat

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earache Headache Sinus Problems

Nose Bleeding Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

14. Respiratory

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis

Shortness of Breath Other Respiratory Problems:

15. Cardiovascular

Heart Disease | Chest Pain | Swelling Ankles | High Blood Pressure | High Cholesterol
Palpitations/Fluttering | Stroke | Heart Murmurs | Rheumatic Fever | Varicose Veins

16. Gastrointestinal

Ulcers | Change in Appetite | Nausea/Vomiting | Epigastric Pain | Excessive Gas | Heartburn
Belching | Gall Bladder Disease | Liver Disease | Hepatitis B or C | Hemorrhoids | Abdominal Pain

17. Genito-Urinary Tract

Kidney Disease | Painful Urination | Frequent UTI | Frequent Urination | Excessive Gas
Kidney Stones | Difficulty Urination | Blood in Urine | Frequent Urination at Night | Scanty Urination

18. Female Reproductive/Breast

Irregular Cycle | Breast Lumps/Tenderness | Nipple Discharge | Heavy Flow | Long Flow (> 7 days)
Vaginal Discharge | Premenstrual Problems(PMS) | Clotting | Painful Periods | Short Flow (< 3 days)
Menopausal System | Difficulty Conceiving | Scanty Flow | Bleeding Between Cycles

19. Male Reproductive

Sexual Difficulties | Prostate Problems | Testicular Pain/Swelling | Penile Discharge

20. Musculoskeletal

Neck/Shoulder Pain | Muscle Spasms/Cramps | Arm Pain | Upper Back Pain | Mid Back Pain
Low Back Pain | Leg Pain | Joint Pain (if so, where?):

21. Neurologic

Vertigo/Dizziness | Paralysis | Numbness/Tingling | Loss of Balance | Seizures/Epilepsy | Concussion

22. Endocrine

Hypothyroid | Hyperthyroid | Hypoglycemia | Diabetes Mellitus | Night Sweats | Feeling Hot or Cold

23. Other

Anemia | Cancer | Rashes | Eczema/Hives | Cold Hands/Feet

Is there anything else that should/could be mentioned?

24. Menstrual/Birthing History:

Age of First Menses: Date of Last Menus: Birth Control Type:
# of Days of Menses: # of Days Between Menus: Total Length of Cycle:
# of Pregnancies: # of Live Births: # of Miscarriages: # of Abortions

25. Lifestyle:

Do you typically eat at least three meals per day? Y / N
Typical daily diet:
How many glasses of non-caffeinated. non-alcoholic, non carbonated beverages do you drink per day?
Exercise routine:
How many hours per night do you sleep? Do you wake rested? Y / N
Occupation: Employer:
Do enjoy your work? Y / N Why/Why not?
Nicotine/Alcohol/Caffeine/ Illicit Substance Use:
Have you experienced any major traumas? Y / N Describe:
Do you feel safe and content in your home?
Interests and hobbies:

26. Oriental Medicine (OM) Pattern Diagnosis Questions:

***all** answers that apply **currently** (today or within the last few days)*

	1	2	3	4	5	6	7	8	9	10
Energy Level:	1 worst	2	3	4	5	6	7	8	9	10 best
Stress Level:	1 worst	2	3	4	5	6	7	8	9	10 best

Sleep: Difficulty Falling asleep Wake frequently Wake early and can't go back to sleep
Frequent dreaming Nightmares Other:
Don't feel rested in the morning Feel rested in the morning

Sweating: Night sweating Sweating without activity/anxiety Normal sweating with activity only

Appetite: Always feeling hungry Appetite seems normal Rarely feel hungry Aversion to food
I eat more than I should I eat the right amount for me I eat less than I should
I prefer: Hot food Cold food Spicy Salty Sweet Bitter Sour Bland

Thirst: Always feeling Thirsty Thirst seems normal Rarely feel thirsty Aversion to drinks
I drink more than others I drink the right amount for me I drink less than others
I prefer: Hot drinks Room Temperature Cold drinks

Bowel Movements: Regular Irregular Mostly regular Laxative use: Y /N
1-2 week Every other day < 1/day 1/day 2-3/day > 3 day
Dry/Hard Sticky Loose/Soft Watery Undigested food bits
Black/Tarry Brown Green Yellow Gray/Silver Blood Mucus Other:

Urination: More than fluid intake Proportional to fluid intake Less than fluid intake
Clear Light Yellow Dark Yellow Brown Pink/Red Cloudy
Pain with urination Frequent urination Urgency Difficulty stopping/starting

How did you out about our office? Referral? Y / N (Who?) Other:

FINANCIAL POLICIES

New Patient Acupuncture Evaluation	$40
Acupuncture Treatment	$80
Chinese Herbs	$ 20
Missed Appointment/Cancelation of 24 hours or less	$80

Please initial the following:

_____ All payments are due in full at the time of service.

_____ Insurance is not accepted, however if your policy covers acupuncture, we can provide paperwork for you to submit to your insurance company your self.

_____ In the event of a missed appointment or an appointment cancelled with notice of 24 hours or less, a $80 fee will be charged.

Please indicate your understanding and acceptance of these policies by signing below.

Signature:__________________ Printed Name:______________________ Date:___________________

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPEREATIONS

I understand that as part of healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care of treatment.

I understand that the information serves as:

- A basis for planning my care and treatment.
- A means of communication among many. professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that service billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professional.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations--and that the - organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of the health information:
____
____

Patient Signature:_______________________________ Date:________________________