Crane Valley Acupuncture
REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Cell Phone	E-mail address	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security no.:			Home phone no.: ( )
P.O. box:	City:		State:		ZIP Code:
Occupation:	Employer:				Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital
❑ Family ❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other
Other family members seen here:			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )
Is this patient covered by insurance? ❑ Yes ❑ No			

Please indicate primary insurance	❑	❑	❑	❑	❑

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

PATIENT NAME

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 1 OF 2 - PLEASE SIGN BOTH SIDES

Article **1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, and procedural disputes will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: **General Provision**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: **Revocation**: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: **Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE (Or Patient Representative) X (Date)

(Indicate relationship if signing for patient)

PLEASE SIGN REVERSE SIDE ALSO

AAC

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 2 OF 2 - PLEASE SIGN BOTH SIDES

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below 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 the acupuncturist named below, 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 (Oriental massage), Oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. 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 a generally 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. 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. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect 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 Oriental 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 treatment, and I wish to rely on 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 that 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 condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE X — Date
(Or Patient Representative) — (Indicate relationship if signing for patient)

OFFICE SIGNATURE — Date

PLEASE SIGN REVERSE SIDE ALSO

FEES, CASH AND PAYMENT AGREEMENT FOR ACUPUNCTURE AND ORIENTAL MEDICINE CARE

TO ALL NEW PATIENTS:

Welcome to our office. We hope that you find our office and staff pleasant.

CANCELING OR CHANGING APPOINTMENTS:

We will set a specific course of treatment for you. A certain number of treatments in a set amount of time is required to get the desired results. If you need to change or cancel an appointment, be sure to make up the missed appointment within a week. If, for some reason you need to cancel your appointment, please call ahead and let us know so that we may accommodate another patient at that time. A no show without cancellation notice 24 hours prior to the scheduled appointment can result in an office visit charge.

UPSETS:

We are here to serve you. Please feel free to speak with the office manager about any upsetting matter.

FEES:

The fees charged at this office are comparable to those charged by other specialists with similar qualifications in this geographic area. The fees for office services are payable at the time of the visit, except in certain cases where arrangements have been made with our office. You will be provided with the necessary receipt so you may bill your insurance company directly.

If you are a patient of an industrial accident, you must provide us with an authorization signed by your employer or supervisor authorizing our office to provide services to you on your first visit. It is also your responsibility to provide us with the name and address of the workers' compensation carrier.

In those cases where payment arrangements have been made with our office and your account becomes past due, we reserve the right to make the financial charge at an interest rate of 1.5% per month for every month that an account remains overdue, after 30 days.

For your information, some of our fees are as follows. Once again, fees (deductible and/or co-payment and/or others) for office services are payable at the time of the visit.

Office Visit (Evaluation & Management)	
a complete history and examination	**$65.00 - $ 100.00**
Acupuncture	**$65.00 - $ 100.00**
Physiotherapy (Hot Pack, Massage, etc.)	**$18.00 per modality/procedure**
Herbology/Herb Formulas/Vitamins	**Priced separately per item**

_____ _____

Patient's Signature Date

INFORMATION FOR HEALTH INSURANCE PATIENTS

We would like to take a moment to welcome you to our office and assure you that you will receive the very best of care available for your condition. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

Explanation of Insurance Coverage:

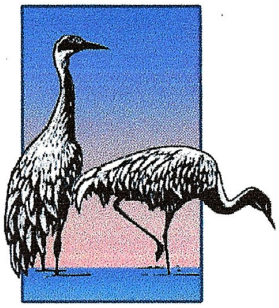
Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

If you want assistance in determining the maximum allowable covered expense for services provided by a physician who is a non-participating provider, you may telephone the claims administrator at the number shown on your identification card and request a Disclosure of Allowable Reimbursement. Gloria Garlands fax number is 642-2466. We will complete the form and fax it back to your insurance to complete the request.

Voluntary Termination of Care

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome your to our office, and will be glad to answer any further questions that you might have.



Gloria Garland L.Ac., Dipl. Ac. & CH
Crane Valley Acupuncture

Office: 49722 Crane Valley Road #101
Mailing: P.O. Box 544, Oakhurst, CA 93644
Phone 559-683-4434 - Fax 559-642-2466

Appointment changes and cancellation policy

This office has a policy of charging a fee for missing an appointment or canceling with less than one working day's notice. This policy is explained at the time of the first visit. **The fee is $50.00.** If for some reason you need to cancel your appointment. Notify us at least 24 hours in advance.

The patient will be reminded once if the initial explanation is forgotten. Then we will expect complete cooperation with future appointment changes.

The purpose of this fee is to encourage our patients to take their appointments as seriously as we do. This time is reserved for you and if you fail to keep an appointment we are unable to accommodate other patients. We set a specific course of treatment for you. A certain number of treatments in a set amount of time are required to get desired results.

Acute health problems and family emergencies are accepted reasons for missed appointments. Last minute schedule conflicts or simply forgetting are not accepted reasons. We are available to discuss this policy in general or individual circumstances.

Thank you for your understanding.
Gloria Garland – Crane Valley Acupuncture

_____ _____

Please initial here Today's date

"Health Insurance Portability & Accountability Act of 1996" ("HIPAA")

Gloria J. Garland, L. Ac., Dipl. Ac. & Ch.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

"HIPAA" is a federal program which requires that all medical records and other personal identifiable health information **("PHI")**, used or disclosed by us in any form, whether electronically, paper or orally be kept private and confidential. This notice applies to the information and records we have about your health, health status, and the health care services you receive at this office. We are required by applicable federal and state law to maintain the privacy of your health information.

We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. This Act gives you (the Patient), significant new rights to understand and control how your health information is used. We must follow the privacy practices that are described in this notice while it is in effect.

This notice takes effect April 13, 2003, and will remain in effect until we replace or revise it.

"HIPAA" provides penalties for organizations that misuse personal health information **("PHI")**.

YOUR HEALTH INFORMATION RIGHTS:
You have the right to request a copy of this privacy notice and to authorize or withdraw your authorization before we use or disclose your **("PHI")**.

You have a right to request a copy of your **("PHI")**, that is kept in your medical or billing record. (Your request must be in writing and we may charge a nominal fee for this service). You have a right to amend your **("PHI")**, if you believe that the information we have about you is incorrect or incomplete, you may request that we correct the existing information or add the missing information to your medical or billing record.

You have a right to request in writing, that we communicate with you about your **("PHI")**, we will do that in a specific way, (for example: at a certain mail address or phone number). We will make every reasonable effort to agree to your request.

You have a right to request in writing that we restrict the use or disclosure of your **("PHI")**, for treatment, payment, healthcare operations, or any other purpose except when specifically authorized by you, when we are required by law, or in an emergency situation in order to treat you. We will consider your request and respond, but we are not legally required to agree if we believe your request would interfere with our ability to treat you or collect payment for our services.

You have the right to request a list of disclosures of your **("PHI")**, that we have made for reasons other than treatment, payment, or other health care operations. Disclosures that we make with your authorization will not be listed. The first list you request with-in a 12-month period will be free, we will charge a nominal fee for any additional lists.

OUR RESPONSIBILITIES:
We are required by **"HIPAA"**, to protect the privacy of your **("PHI")**, establish policies and procedures that govern the behavior of our workforce and business associates, and provide this notice about our privacy practices.

We reserve the right to change our policies and procedures for protecting your **("PHI")**. When we make any significant changes in how we use or disclose your **("PHI")**, we will also change this notice.
The new notice will be posted in the front office lobby, and will be available at the front desk and in our medical and billing records department.

Except for the purposes related to your treatment, to collect payment for our services, to perform necessary business functions, or when otherwise permitted or required by law, we will not use or disclose your **("PHI")**, without your authorization.

You have the right to revoke your authorization at any time.

We are unable to take back any disclosure we have already made with your permission.

EXAMPLES OF USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS:
We will use your **("PHI")**, to facilitate your medical treatment. (For example: Information in your medical record will be used to determine the course of your treatment.

We will provide your primary care provider, or other health care providers involved with your treatment, with copies of reports that may assist them in treating you.

We will use your ("PHI"), to collect payment for health care services that we provide. (For example): A bill may be sent to your health insurance company or to you. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

In some cases, information from your medical record will be sent to your insurance company to explain the need for or to provide additional treatment. We may also disclose medical information to other health care providers to assist them in obtaining payment for services they have provided to you.

We will use you're ("PHI"), to facilitate routine health care operations: (For example): Members of our Medical Staff may use information in your medical record to access the care you have received and how your progress compares to others.

We will use your ("PHI"), to notify your family or close friend about your condition, or in the event of your death. (For example): We may use or disclose you're **("PHI")**, to notify or assist in notifying a family member, personal representative, or other person responsible for your care.

Health care professionals, using their best judgment, may disclose to a family member or other relative, or close personal friend, relevant health care information to facilitate the person's ability to assist you in your care.

EXAMPLES OF USES AND DISCLOSURES FOR OTHER PURPOSES:
Appointment Remainders: We may contact you to remind you of an upcoming appointment.

Marketing:
We may use or disclose your **("PHI")**, to inform you of our health care services, treatment alternatives, or other health-related benefits or services that may be of interest to you.
We may also inform you of commercial products or services when we think they would be of interest to you.

Worker's Compensation: We may disclose your **("PHI")**, to your employer and Worker's Compensation carrier as authorized by laws relating to Worker's Compensation or other similar programs established by law.

As required by law: We will use and disclose your **("PHI")**, to comply with federal and state laws, which include reporting abuse, neglect, or domestic violence, responding to judicial or administrative proceedings, complying with audits, responding to law enforcement officials, reporting health and safety threats, or reporting to public health authorities or other federal agencies.

Food and Drug Administration ("FDA"): We may use and disclose to the **("FDA")**, your **("PHI")**, relating to adverse effects with respect to food, nutritional supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Device Manufactures: If you receive a medical device that is implanted or which is used for life support function, we may disclose your name, address, and other information as required by law to the device manufacturer for tracking purposes. **You may refuse to authorize the disclosure of your name and contact information.**

Business Associates: There are some services provided through contracts with business associates. (Examples include): certain laboratory tests, X-ray or MRI reports, patient satisfaction surveys, and the copy service we use when making copies of your medical or billing records.
When these services are provided by contracted business associates, we may disclose the appropriate portions of your **("PHI")**, to our business associates so they can perform the job we have asked them to do.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:
If you have questions, or would like additional information, or want to request a copy of this notice, you may contact: Gloria J. Garland, L. Ac., Dipl. Ac. & Ch. (559) 683-4434

If you believe we have not properly protected your privacy, violated your privacy rights, or you disagree with a decision we have made about your rights, you may contact the privacy officer at Gloria J. Garland, L. Ac., Dipl. Ac. & Ch. (559) 683-4434

You may also send a written complaint to the:

U.S. Department of Health and Human Services
Office of Civil Rights, Attn: Regional Manager
50 United Nations Plaza, Room 322
San Francisco, CA 94102 (415) 437-8310

Patient Signature: _____ **Date:** _____

Confidential Health History

Please complete as accurately as possible

Name:_____ Today's date:_____

Birth date:_____ Date of last physical exam:_____

Chief health concerns you wish to address:

1._____ 2._____

3._____ 4._____

When did this condition begin? _____

What makes it better? _____

What makes it worse? _____

What treatment have you already received? _____

What medical tests were given? Please include results. _____

Allergies/Sensitivities

Type	Typical Reaction
(Specify, drugs, food, environment, etc.)	(Itching, redness, etc..)

List any Herbs / Supplements / Homeopathics you are currently taking:	
Type	**Dosage**

Place an X at the site of your pain on the model below.

What makes it better?_____

Worse?_____

Please circle Y = yes N = no:

Better with pressure? Y N

Worse with pressure? Y N

Nature of pain? (***circle***)

Sharp / dull / ache / throb / burning/ heavy

Please give a rating of your pain:_____

Pain scale: 0 = no pain 5 = moderate 10 = severe

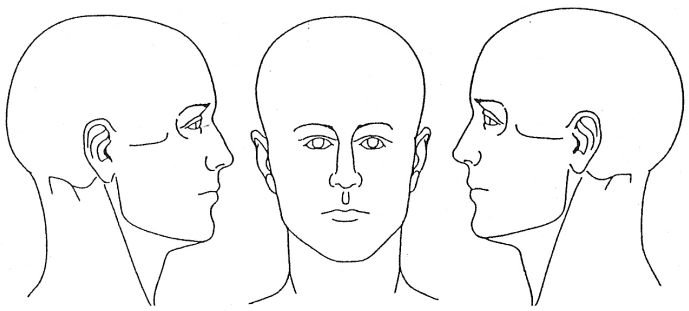
Does the pain come and go? Y N

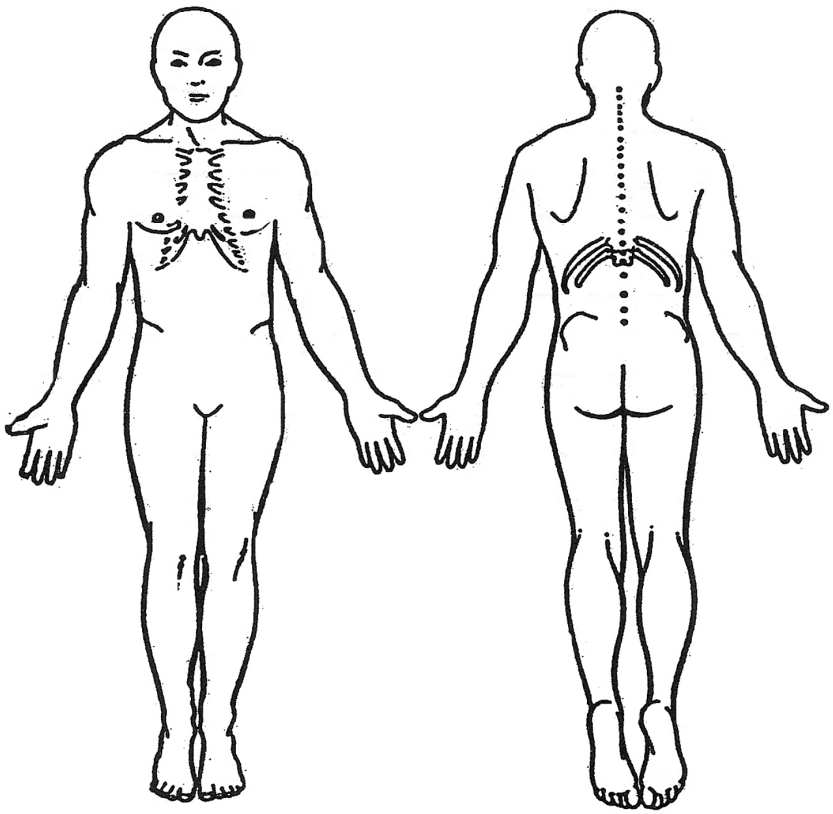
Is it constant? Y N

Does the pain move around? Y N

Is the pain fixed in one location? Y N

Does the pain radiate? Y N
(If so, please indicate on model.)





Do you generally feel hot or cold?_____ Do your hands / feet feel hot or cold?_
Do you feel thirsty? _____ Prefer warm or cool drinks?_____
Extremely thirsty? _____
Feel extremely hungry?_____ Any aversions or extreme desire/cravings for tastes?
salty sour sweet bitter spicy

Sleep pattern: Y = yes N = no (please circle)
How many hours at night?_____ Able to sleep through the night? y n
What wakes you at night? _____
Easy to awake in the morning? y n Difficult to get up in the morning? y n
Do you have vivd dreams? y n Recurring themes or images? y n

Energy: On a scale of 0 - 10, please rate your energy level at this time: 0 1 2 3 4 5 6 7 8 9 10
0 = difficult to even get out of bed 10 = able to run the LA marathon

Describe a typical day's diet:		
Breakfast	**Lunch**	**Dinner**

How much water do you drink daily?_____ Diet restrictions?_____
What percent of food do you prepare yourself?_____
Any cravings for: sweet starch salt fat meat sour dairy

Describe your current **exercise/physical** fitness program:_____

Please indicate the following by circling the word or filling in the blank:

Chills: onset?_____ **Sweating:** spontaneous / on exertion

Fever: onset?_____ nightime afternoon

hands feet

Daily urination: Other:_____

How many times / day?_____ How many times / night?_____

(circle) clear cloudy yellow dark hesitant dribbling painful

Bowel movements:

How many times / day? Regular? yes no Use laxatives? yes no Type?_____

Constipation?_____ Days between bowel movements? _____

Diarrhea ? How often?_____

Feeling of incomplete BM?_____ Feeling of bearing down sensation?_____

(circle) loose stool dry long &thin floating pebble like clay like bloody

Color?_____ soft formed normal

Women Only:

Menstrual History: Age at onset?_____ Date of last menstrual period?_____

Length of cycle between periods?_____ Regular or irregular cycle?_____

Length of flow ? _____ Do you think you are pregnant?_____

Color of blood: **(circle)** Consistency of blood:

bright red dark red brown purple sticky thick clots watery

begins dark then turns red begins with clots then becomes watery

Date of last PAP smear?_____

PMS: (circle)

breast distention cramps: before / during / after headaches? onset? breast lumps

mood swings crave sweets bloating edema crying spells

vaginal discharge? color?_____ hot flashes nipple discharge

Having difficulty getting pregnant?_____

Number of pregnancies? _____ Number of children?_____

Are you taking birth control? Type?_____ HRT?_____ dose?_____

Men Only:

Urology history: **(circle)**

Premature ejaculation Impotence Prostate problems

Infertility breast lump lump in testicles Other:_____

List any medications you are currently taking:	
Type	**Dosage**

Please indicate with a checkmark if you have had any of the following:

Aids	Glaucoma	Prostate problems
Allergies	Heart Disease	Rheumatic fever
Anemia	Hepatitis	Scarlet fever
Arthritis	High Cholesterol	STD (specify)
Asthma	HIV	Stroke
Bleeding disorders	Irritable bowel disease	Suicide attempt
Breast Lump	Kidney disease	Surgical implants
Cancer	Kidney stones	Thyroid problems
Candidiasis	Liver disease	TB
Pacemaker	Lung disease	Typhoid
Chronic fatigue	Lupus erythrematosus	Gastric ulcer
Colitis/Crohn's	Meniere's	Bladder problems
Diabetes	Migraine	Vaginal infections
Eating disorder	Multiple Sclerosis	Other: _____
Eczema	Nerve disorders	History of smoking? _____
Epilepsy	Endometriosis	how much? _____ years? _____
Fibromyalgia	PID	Recreational drugs? _____ frequency? _____
Gallstones	Polio	Alcohol use? _____ frequency? _____

Immunizations: (circle) Mumps Rubella Small pox Measles Influenza Tetanus TB

How was your overall health as a child? excellent good fair poor

Family Health History:			
Relation		**Age**	**State of health**
Father			
Mother			
Brother			
Sister			

Checkmark if any family member had: (include grandparents)

Arthritis/Gout	Heart disease	Other: _____
Asthma	High blood pressure	_____
Cancer	Diabetes	

Please list any serious illnesses / injuries / surgeries:	Date:	Outcome:

Environmental / Occupational / Social

(Please circle response) How many hours per week do you work?

Do you enjoy your work? yes no

Do you have a supportive work environment? yes no

Are you exposed to: smoke chemicals other toxins?_____

Do you have a supportive work environment? yes no

Are you satisfied with your relationships? spouse/partner: yes no family: yes no

coworkers: yes no social contacts: yes no

How is your emotional health? good fair poor varies

Please list **two** emotions that influence your life which are experienced frequently or are difficult to express: _____ _____

Describe any **traumatic** experiences you have had and give approximate dates: (I.e. divorce, death in the family, bankruptcy, injuries, etc.)	
Date:	**Event:**

Do you feel you have a good support network? yes no

Are you currently in psychotherapy? yes no

Are you taking antidepressant medications? yes no Specify:_____

Please indicate for each of the questions below, your experience by use of one of the following codes.
Codes: 1 for **never** had; 2 for **previously** had; 3 for **presently** have.

MUSCULO-SKELETAL SYSTEM

CODE

_____ Neck problems
_____ Arm problems
_____ Pain between shoulders
_____ Low back problems
_____ Leg problems
_____ Swollen joints
_____ Painful joints
_____ Stiff joints
_____ Sore muscles
_____ Weak muscles
_____ Walking problems
_____ Ruptures of tendons
_____ Broken bones

GENITO-URINARY SYSTEM

CODE

_____ Bladder trouble
_____ Excessive urine
_____ Scanty urination
_____ Painful urination
_____ Discolored urine

FEMALE

CODE

_____ Vaginal Discharge
_____ Vaginal bleeding
_____ Vaginal pain
_____ Breast pain
_____ Lumps on breast

GASTRO-INTESTINAL SYSTEM

CODE

_____ Poor appetite
_____ Excessive hunger
_____ Excessive thirst
_____ Difficulty chewing
_____ Difficulty swallowing
_____ Nausea
_____ Vomiting food
_____ Vomiting blood
_____ Abdominal pain
_____ Diarrhea
_____ Constipation
_____ Black stool
_____ Bloody stool
_____ Hemorrhoids
_____ Liver trouble
_____ Gall bladder problems
_____ Weight gain/loss

NERVOUS SYSTEM

CODE

_____ Numbness
_____ Paralysis
_____ Dizziness
_____ Fainting
_____ Headaches
_____ Muscle jerking
_____ Convulsions
_____ Forgetfulness
_____ Confusion
_____ Depression

CARDIO-VASCULAR-RESPIRATORY

CODE

_____ Chest pain
_____ Heart Pain
_____ Rapid heart beat
_____ Blood pressure high/low
_____ Heart problems
_____ Difficult breathing
_____ Persistent cough
_____ Coughing up phlegm
_____ Coughing up blood
_____ Lung problems
_____ Varicose veins

EYE, EAR, NOSE AND THROAT

CODE

____ Eye strain
____ Eye inflammation
____ Vision problems
____ Ear pain
____ Ear noises
____ Hearing loss
____ Ear discharge
____ Nose pain
____ Nose bleeding
____ Nose discharge
____ Difficult breathing throug nose
____ Sore gums
____ Dental problems
____ Sore mouth
____ Sore throat
____ Hoarseness
____ Difficult speech

Please list any serious illnesses / injuries / surgeries:	Date:	Outcome:

Environmental / Occupational / Social

(Please circle response) How many hours per week do you work?

Do you enjoy your work? yes no

Do you have a supportive work environment? yes no

Are you exposed to: smoke chemicals other toxins?_____

Do you have a supportive work environment? yes no

Are you satisfied with your relationships? spouse/partner: yes no family: yes no

coworkers: yes no social contacts: yes no

How is your emotional health? good fair poor varies

Please list **two** emotions that influence your life which are experienced frequently or are difficult to express: _____ _____

Describe any **traumatic** experiences you have had and give approximate dates: (I.e. divorce, death in the family, bankruptcy, injuries, etc.)	
Date:	**Event:**

Do you feel you have a good support network? yes no

Are you currently in psychotherapy? yes no

Are you taking antidepressant medications? yes no Specify:_____

Please check any that apply:

I.

- ❑ Bronchitis
- ❑ Difficult to exahle
- ❑ Wheezing
- ❑ Cough
- ❑ Sinus congestion
- ❑ Nasal infections
- ❑ Dry skin
- ❑ Itchy skin
- ❑ Rashes
- ❑ Spontaneous sweating
- ❑ Hands/feet sweat
- ❑ Catch cold easily
- ❑ Shortness of breath
- ❑ Low weak voice
- ❑ Toothaches
- ❑ Runny nose
- ❑ Abdominal pain
- ❑ Constipation / diarrhea
- ❑ Chest feels tight
- ❑ Difficult urination
- ❑ Craves spicy taste

II.

- ❑ Hearing loss
- ❑ Ringing in the ears: Hi pitch / low pitch?
- ❑ Dizziness
- ❑ Low back ache
- ❑ Neck pain
- ❑ Sinus congestion
- ❑ Dark circles under eyes
- ❑ Edema
- ❑ Emotional instability
- ❑ Aversion to cold
- ❑ Cold hands/feet
- ❑ Hair thinning/loss
- ❑ Premature aging
- ❑ Frequent urination
- ❑ Kidney stones
- ❑ Sweat easily
- ❑ Night sweats
- ❑ Afternoon fever
- ❑ Weak legs/knees
- ❑ Sore knees
- ❑ Difficult inhalation
- ❑ Asthmatic cough
- ❑ Rapid weight change
- ❑ Loose teeth
- ❑ Reduced sexual energy
- ❑ Increased sexual energy
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Poor memory
- ❑ Fatigue
- ❑ Craves salty taste
- ❑ Thirsty for hot drinks

III.

- ❑ Headaches
  - ❑ Frontal
  - ❑ Side of head
  - ❑ Back of head
  - ❑ Top of head
  - ❑ Whole head
- ❑ Migraines
- ❑ Ringing in ears Hi pitch / low pitch?
- ❑ Vision problems
- ❑ Blurry vision
- ❑ Spots / floaters
- ❑ Dry red eyes
- ❑ Excessive tearing / watery eyes
- ❑ Eye infections
- ❑ Eczema
- ❑ Shingles
- ❑ Herpes: type_____
- ❑ Warts
- ❑ Alternating constipation / diarrhea
- ❑ Hepatitis: type_____
- ❑ Ulcers
- ❑ Vomiting
- ❑ Gallstones
- ❑ Bitter taste in mouth
- ❑ Fullness/distention along the ribcage
- ❑ Neck tension
- ❑ Insomnia 11pm – 3am
- ❑ Craves sour taste
- ❑ Indecisive
- ❑ Depression
- ❑ Anger easily
- ❑ Irritable
- ❑ Nervous
- ❑ Numbness/tingling in the extremities
- ❑ Spasms/trembling
- ❑ Dizziness
- ❑ Feels like something stuck in the throat
- ❑ Nailbeds: pale/ridges

IV.

- ❑ Dry scalp
- ❑ Skin rashes/eruptions
- ❑ Sore throat/tonsillitis
- ❑ Lymphatic swelling
- ❑ Hot hands/feet
- ❑ Aversion to heat
- ❑ Dry mouth
- ❑ Gum problems
- ❑ Nosebleed
- ❑ Facial redness
- ❑ Palpitation
- ❑ Thirsty for cold drinks
- ❑ Vivid dreams
- ❑ Dark urine
- ❑ Night sweats
- ❑ Chest pain
- ❑ Insomnia
  - ❑ Difficult to fall asleep
  - ❑ Waking up frequently
- ❑ Mouth ulcers
- ❑ Tongue ulcers
- ❑ Thirsty but only for small sips
- ❑ Very thirsty constantly
- ❑ Fatigue upon waking
- ❑ Craves bitter taste
- ❑ Sweat easily

V.

- ❑ Indigestion
- ❑ Gas
- ❑ Bloating
- ❑ Stomach ache
- ❑ Stomach ulcer
- ❑ Loose stools
- ❑ Bad breath
- ❑ Acid regurgitation
- ❑ Heartburn
- ❑ Increased appetite
- ❑ Decreased appetite
- ❑ Nausea
- ❑ Vomiting
- ❑ Low body weight
- ❑ Gains weight
- ❑ Mouth sores
- ❑ Food allergies
- ❑ Craves sweet taste
- ❑ Always hungry
- ❑ Hungry but don't eat
- ❑ Anemia
- ❑ Extremities feel heavy
- ❑ Bruises easily
- ❑ Prolonged bleeding
- ❑ Urine/bowel incontinence
- ❑ Varicose veins
- ❑ Fatigued
- ❑ Muscles feel weak
- ❑ Sticky saliva
- ❑ Thirsty but prefer not to drink
- ❑ Vaginal infections
- ❑ Hemorrhoids
- ❑ Abdominal pain
- ❑ Epigastric pain (below sternum)

Indicate which words describes you now or in the past:

- ❑ Indecisive
- ❑ Fearful
- ❑ Very analytical
- ❑ Obsessive
- ❑ Thorough
- ❑ Impatient
- ❑ Authoritative
- ❑ Competitive
- ❑ Nervous
- ❑ Sensitive
- ❑ Passive
- ❑ Hesitant
- ❑ Secretive
- ❑ Lack self confidence
- ❑ Depressed
- ❑ Anxious
- ❑ Private
- ❑ Apprehensive
- ❑ Mildly paranoid about certain things
- ❑ Lack of will / motivation
- ❑ Very self disciplined
- ❑ Rather follow than lead
- ❑ Rather lead than follow
- ❑ Shamed
- ❑ Guilty
- ❑ Talkative
- ❑ Creative
- ❑ Impulsive
- ❑ Restless
- ❑ Passionate
- ❑ Frequently Irritable
- ❑ Frequently angry
- ❑ Easily angered
- ❑ Dramatic
- ❑ Clear thinking
- ❑ Decisive
- ❑ Moody
- ❑ Self analytical
- ❑ Responsible
- ❑ Organized
- ❑ Hold grudges
- ❑ Difficulty letting go of the past
- ❑ Reliable
- ❑ Joyful
- ❑ Frustrated
- ❑ Fidgety
- ❑ Cries easily
- ❑ Feel calm
- ❑ Able to sit quietly