Asian THERAPEUTICS

2131 Capitol Avenue, Suite 307
Sacramento, CA 95816
(916) 444-2177

# PATIENT CONFIDENTIAL INFORMATION

Name _____
First Middle Last

Address _____
Street City State Zip

Preferred Phone _____ Email _____

I DO NOT wish to receive occasional educational and promotional notices. ☐

Age _____ Date of Birth _____ Sex _____ Height _____ Weight _____

How did you find out about us? _____

Occupation _____ Employer _____

In case of emergency, call _____
Name Street City Phone

Primary Physician Name _____

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FOR ALL PATIENTS: Do you have a pacemaker or other electronic implant? _____ IF YES, SINCE WHEN? _____

FOR FEMALES: Are you pregnant? _____ IF YES, HOW LONG? _____

FOR MINORS: List guardian's name and address

_____

_____

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## FINANCIAL ARRANGEMENTS

How do you plan to handle your account? (Check one) ☐ Cash ☐ Check ☐ Master Card ☐ Visa

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## CANCELLATION POLICY

The time that is scheduled for you is not available to any other individual. A late cancellation/no-show fee of $25 per occurrence will apply if you cancel or change your appointment on the day you are scheduled (unless it is an emergency).

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I agree to the aforementioned terms. I assert that, to the best of my knowledge, all information herein is correct and complete. I authorize communication between my acupuncturist and my other medical providers to coordinate my care.

PATIENT'S SIGNATURE _____ DATE: _____
(parent/guardian's signature if patient is minor)

# Patient Confidential Health History

Please help me provide you with a thorough evaluation by taking the time to complete this questionnaire carefully. As with all of our correspondence, your answers will be completely confidential. If there is anything that you feel I should know that is not asked, please write it either in the margin or at the bottom of the page. If you have any questions, please don't hesitate to ask.

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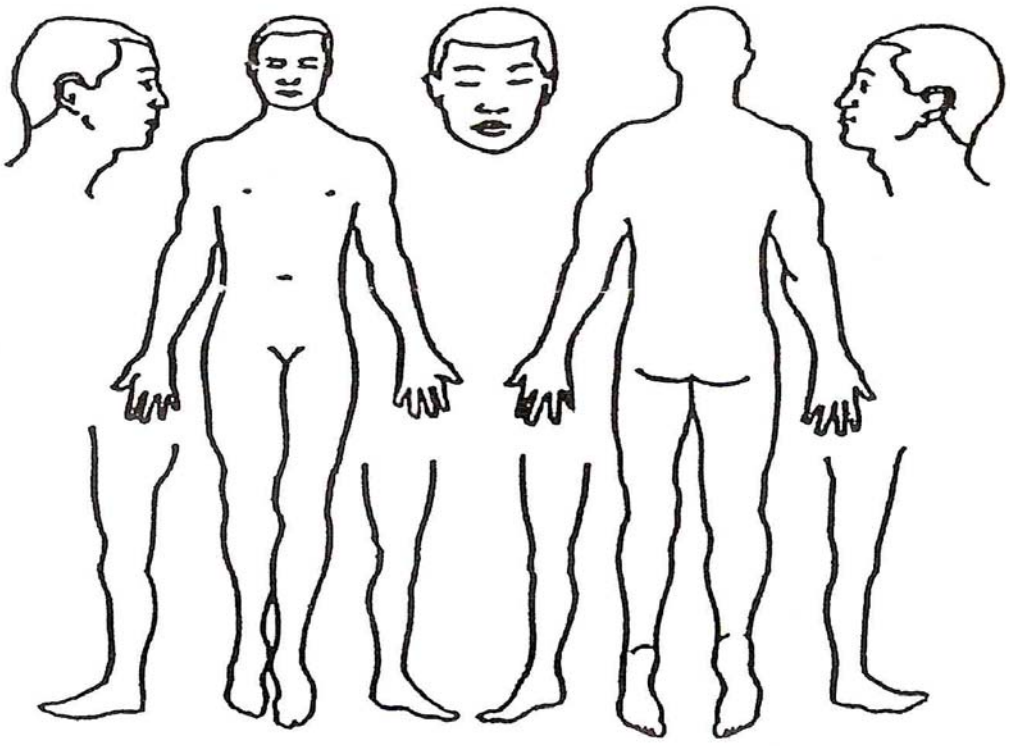
|---|
| Have you had acupuncture before? How recently? |
| In addition to acupuncture treatment, would you like to discuss herbal medicine that may be helpful? |
| Main problem(s) you would like help with: |
| How long ago did each problem begin? |
| To what extent does this problem interfere with ability to function (eg. work, home, sleep, digestion, exercise, sex)? |
| Have you received a diagnosis from a medical professional? If so, what? |
| What treatments have you tried (chiropractic, massage, self-treatment like ice/heat/rest)? Does anything help? |

**Please indicate any painful or uncomfortable areas**



## Lifestyle Factors

Medications taken within the last two months – *please include vitamins, herbs, etc.*

What do you do for exercise? How often?

Do you restrict your diet in any way? *(vegetarian, no red meat, etc.)*

| | |
|---|---|
| Approximately how much water do you drink a day? | How much caffeine do you drink? |
| Do you use tobacco? If so, what kind (cigarettes, cigars, etc.) and how much? | How many alcoholic beverages do you typically drink in a week? |

## Past Medical History

Significant Illnesses – *please circle and include approx. date*

Cancer Hepatitis Diabetes High Blood Pressure Heart Attack Stroke Seizures Other

| | | |
|---|---|---|
| Surgeries – *please include approx. date* | Hospitalizations – *please include approx. date and reason* | Significant Trauma *(sports, fractures, falls, auto accidents, etc.)* |

Allergies *(medications, foods, chemicals, etc.)*

## Family Medical History

| | | | | |
|---|---|---|---|---|
| □ Cancer | □ Hepatitis | □ Diabetes | □ High Blood Pressure | □ Heart Attack |
| □ Stroke | □ Seizures | □ Asthma | □ Allergies | □ Other _____ |