Tao of Medicine, Acupuncture & Wellness

2222 Santa Monica Blvd. Suite 307, Santa Monica, CA 90404 (Tel)310-401-3347

PATIENT INFORMATION

Patient:_____

Address:_____

_____
City Sate Zip

Phone:Home:_____

Mobile:_____

Email :_____

Sex: __M __F Age:_____ Birthdate:_____

__Single __Married __Widowed __Separated __Divorced

Patient SS#:_____

Driver's License No.:_____

Occupation:_____

Employer:_____

Employer Address:_____

Employer Phone:_____

Emergency Contact

Name:_____

Phone:_____

Relationship:_____

INSURANCE

Who is responsible for this account?:_____

Subscriber Name_____

Birthdate_____ ID#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Covered by additional insurance? __Yes __No

Payment Information:

Credit Card (circle one): MC / VISA

Card #:_____

Exp Date: _____/_____Security Code: _____

Authorizing Signature:_____

Date:_____

Referred by: _____

*Our Office Policy (***Assignment and Release***)*

1. If you need to cancel your appointment, please inform us at least 24 hours prior to your appointment to avoid a full service charge. A missed appointment will be charged at a full rate.
2. There is a service charge of $30.00 for every returned check from the bank.
3. I authorize the release of any medical records/other information necessary to process a claim with my insurance.
4. I authorize payment of benefits of my insurance to be made directly to this healthcare provider and I understand I am responsible for charges not covered by my insurance benefits.
5. If you are under 18 years of age, please have your parent or legal guardian sign below.

I have read and agree to the terms of the preceding paragraphs. All the information is true to the best of my knowledge.

Signature:_____ Date: _____

MEDICAL HISTORY All information is strictly confidential

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

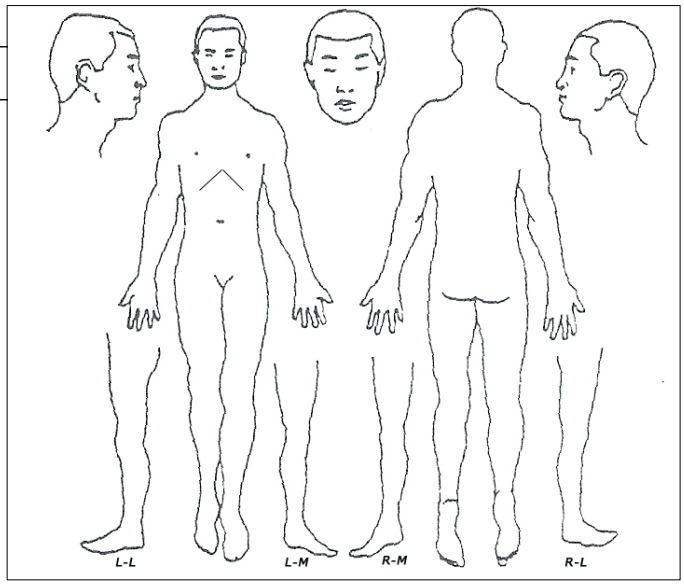
1. When and where did you last receive health care?_____

   For what reason?_____

2. Please identify the health concern that has brought you here today:

   A. _____

   - When did it first occur? Or diagnosed?_____ *please mark the area(s) affected below*
   - How long have you had this problem?_____
   - Related to: □ accident □ job injury □ other_____
   - Pain is: □ minimal □moderate □ sharp □ stabbing
     □ dull □ aching □ shooting □ severe
     □ getting worse □ constant □ come & goes
   - What makes your condition worse?
   - What makes your condition better?



   B.Other concerns:_____

   _____

3. Please answer the following questions by circling the correct answer.

   Do you have a tendency to faint? Yes No
   you HIV positive? Yes No
   Do you have a pacemaker? Yes No (Women)
   you pregnant? Yes No
   Do you bleed for a long time? Yes No
   Have you ever had Hepatitis? Yes No

4. Sexually Transmitted Disease: □ Gonorrhea □ Syphilis □ HPV □ Chlamydia □ Herpes

5. Please list any medications and supplements you are currently taking (attach separate page if necessary):

Medicine	Dosage	Reason	How Long	Doctor's Name	Last Check-up

6. Height: _____ Weight: Currently: _____ Past Maximum: _____ When? _____

7. Blood Pressure: _____ When was this reading taken?_____

8. Skin: □ dry □ itchy □ moist/clammy □ burning □ changing moles or lumps (cysts/tumors) □ acne
□ hair loss/thinning □ dry scalp/dandruff

9. Bowels: Number of movements a day:_____ If less than one a day, how many per week? _____
You have: □ constipation □ diarrhea/loose stools □ bloody stools □ black stools □ white/light color stools
□ mucus in stools □ hemorrhoids □ unusually foul smelling stools □ colon problems
□other:_____

10. Urination: How many times do you urinate a day? _____
□ normal color (pale yellow) □ clear □ dark yellow □ reddish □ cloudy □ has odor □ burning □ painful □ difficult/weak □ urgent

11. How was your health as a child? (circle one) excellent / good / fair / poor.
If fair or poor, why?_____

12. Hospitalizations, Surgeries, and Accidents – please include dates, reasons for use, and outcomes:_____
_____
_____
_____

13. X-Rays/CAT Scans/MRI's/NMR's/Special Studies- please include dates, reasons for use:_____
_____
_____
_____

FAMILY HISTORY

Father	Current health or cause of death	Mother	Current health or cause of death
□ Alive □ Deceased		□ Alive □ Deceased	

	No. Alive	Age & Health	No. Deceased	Cause of & Age at Death
Brother(s)				
Sister(s)				

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES __Diabetes __Cancer __Allergy

__Bleeding tendency __Kidney disease __Tuberculosis __Heart disease __Stroke __High blood pressure

__Nervous illness __Other_____

- Check (X) symptoms you currently have or have had in the past.

		KD	
( )	Fatigue	( )	Memory problems
( )	Feverish in the afternoon or hot flashes	( )	Hair loss
( )	Heat sensations in the hands, feet, chest	( )	Ringing in ears: □ low pitch or □ high pitch?
HT		( )	Night sweating
( )	Mood swings	**SP / ST**	
( )	Heart murmur	( )	Slow healing wounds
( )	High blood pressure	( )	TMJ / grinding teeth
( )	Palpitations	( )	Shortness of breath (□ inhale or □ exhale)
( )	Sores on the tip of tongue	( )	Appetite : □ low or □ excess
( )	Anxiety / nervousness / fidgety /restless	( )	Abdominal bloating or gas after eating
( )	Chest pain radiating to shoulder	( )	Feeling tired after eating
( )	Ankle swelling	( )	Prolapsed organs(previously diagnosed)
( )	Stutter	( )	Bruise easily
LU		( )	General feeling of heaviness in the body
( )	Sweat easily, even with little exertion	( )	Mental sluggishness / forgetfulness / exhaustion
( )	Cough	( )	Swollen hands / feet
( )	Sinus congestion / pressure	( )	Burning sensation after eating
( )	Dry mouth, throat, nose or skin	( )	bad breath (foul/putrid)
( )	Allergies / hay fever	( )	Mouth sores(canker sores)
( )	Catch colds and flu easily	( )	Bleeding, swollen painful gums
( )	Asthma	( )	Heartburn / belching
( )	Frequent sore throats	( )	Stomach pain / stomach ulcer
( )	Chills alternating with fever	( )	Vomiting
( )	Stiff neck / shoulders	( )	Varicose veins
( )	Difficult breathing	( )	Eczema / hives
LV		( )	Anemia
( )	Dirarrhea alternating with constipation	**SJ / PC**	
( )	Tight feeling in the chest		
( )	Bitter taste in the mouth		
( )	Blood shot eyes / dry eyes		
( )	Anger easily		
( )	Skin rashes		
( )	Headaches – location:		
( )	Numbness of hands and feet		
( )	Muscle spasms, twitching, cramping		
( )	Seizure / convulsions	**Allergies / Sensitivities**	
( )	See floating black spots in the eyes	( )	Animal hair / dander /Dust/ molds /weeds/ pollen
( )	Blurred vision	( )	Chemicals:
( )	One-sided pain / discomfort	( )	Food:
( )	Pain / tenderness in the ribs	( )	Medication:
( )	Neck shoulder tension / pain	( )	Others:

Men Only *Please put a check mark by the symptoms that pertain to you.*	
( ) Feeling of coldness or numbness in the external genitalia	( ) Low sex drive
( ) Pain or swelling of testicles	( ) Lack of sex drive
( ) Premature ejaculation	( ) Discharges
( ) Impotence / erectile dysfunction	( ) Painful/burning urination
( ) Prostate problem Other:	

Women Only *Please answer each question.*	
A. Are you currently pregnant? □ Y □ ☐N□ maybe	K Date of last period:
B. No. of pregnancies:	L. Date of last PAP smear test:
C. No. of miscarriages:	M. Age of first period:
D. No. of abortions:	N. Age of last period:
E. Menstrual Cycle – how many days?	
F. Average number of days of flow:	
G. The flow is: normal, heavy, light/scanty	
H. The color is: normal, dark, purple, light brown, brown, bright red, light red / pink (circle as many that apply)	
I. Are you on birth control? Y / N, if yes, How long?	
J. If you are on birth control to regulate your menses, please describe what your menses were like prior to going on the pill (e.g. irregular, painful, heavy):	
Please check the appropriate responses.	
( ) menopausal symptoms	( ) vaginal discharge
( ) premenopausal symptoms	( ) nipple discharge
( ) PMS	( ) vaginal itching
( ) bleeding between cycles	( ) endometriosis
( ) low back pain	( ) fibroids
( ) Painful periods	( ) ovarian cysts / PCOS
( ) blood clots	( ) UTIs
( ) irregular cycle	( ) polyps
( ) breast lumps / tenderness	( ) pelvic inflammatory disease
( ) difficulty conceiving	Operations:
( ) water retention	( ) Cervix
( ) missed periods	( ) Uterus
( ) food cravings:	( ) Ovaries
( ) fatigue w/periods	( ) headaches w/periods
( ) others:	

LIFESTYLE

a. How many full meals a day do you eat? _____ Do you snack in between meals? _____If yes, how many? _____

b. Please describe your typical daily diet:
☐☐ Breakfast _____
☐☐ Lunch _____ What percent of your food
☐☐ Dinner _____ do you prepare
☐☐ Snacks _____ yourself? _____%

c. Are you satisfied with your diet? Y / N Do you diet often? Y / N

d. Do you have any dietary restrictions (e.g. vegetarian, low salt)? Y / N
☐☐ Please specify:_____

e. Any nutritional concerns you would like to discuss? _____

f. Please indicate the use and frequency of the following?

	Yes	No	Daily Amount		Yes	No	Daily Amount
Coffee/Black tea				☐Tobacco			
Recreational Drugs				Alcohol			
Water intake				☐Soda/Coke			

g. Exercise routine(eg: how many time per week, Intensity or time spent)

_____

h. Are you regularly exposed to: ☐☐smoke ☐☐chemicals/chemical fumes ☐☐other toxins?

i. How is your emotional health or stress level ? (circle one) good fair poor varies

j. Have you experienced any major emotional or physical traumas? Y / N

Explain: _____

Thank you

I certify that the above information is correct to the best of my knowledge. I will not hold my acupuncturist or any members of his/her staff responsible for any errors or omission that I may have made in the completion of this form.

Signature_____ Date_____