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

Patient's Name:

Show me where it hurts

Pick A Number And Put It Where It Hurts You.

PATIENT COMPLAINTS:

PAIN SCALE

No Pain Minimal Slight Moderate Severe Pain

0 1 2 3 4 5 6 7 8 9 10

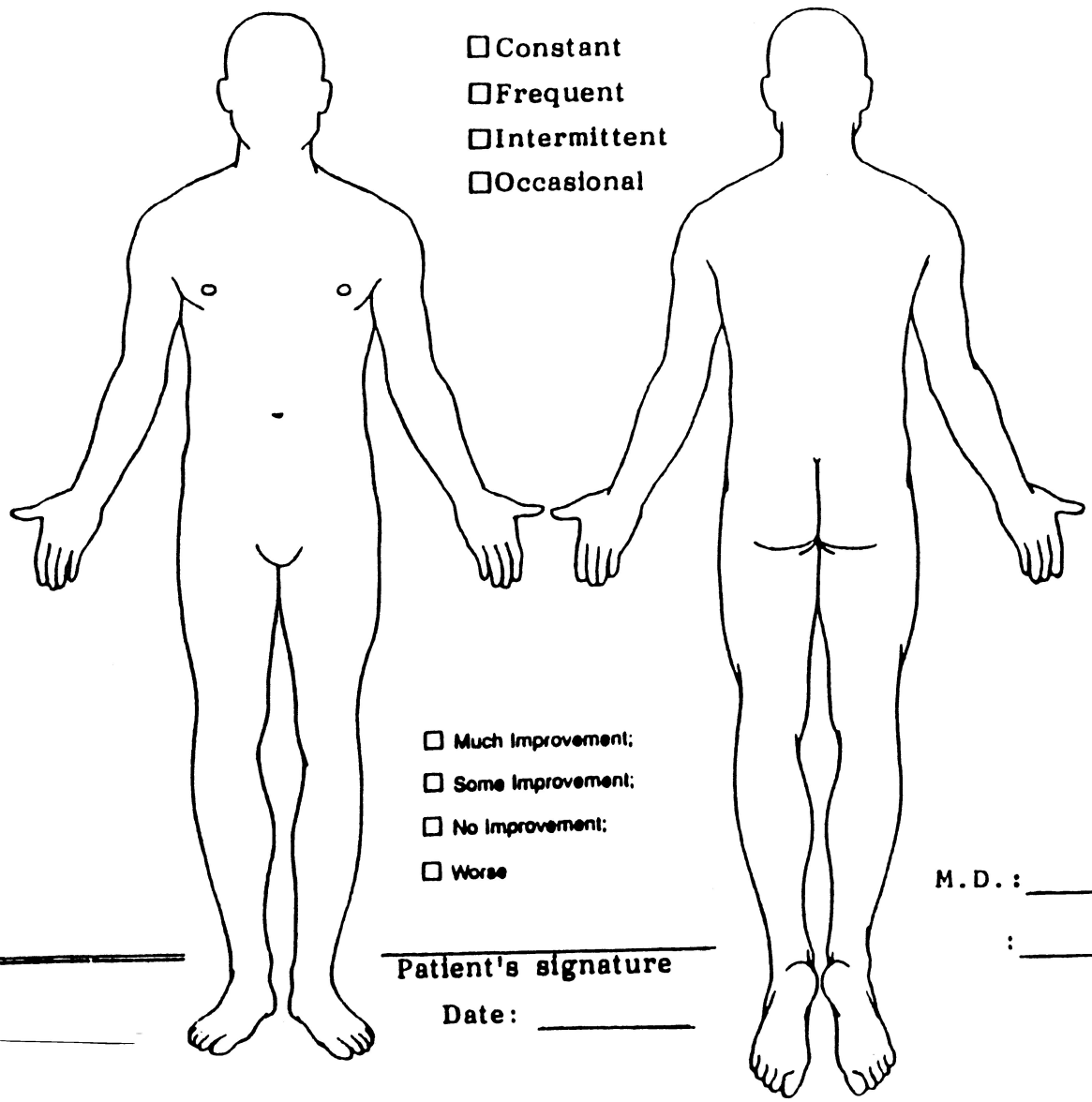
☐ STRESS ☐ TENSION ☐ DEPRESSION

None Mild Moderate Severe

0 1 2 3 4 5 6 7 8 9 10

MY PAIN IS:

- ☐ Constant
- ☐ Frequent
- ☐ Intermittent
- ☐ Occasional



- ☐ Much Improvement;
- ☐ Some Improvement;
- ☐ No Improvement;
- ☐ Worse

Patient's signature

Date: _____

M.D.: _____

: _____

form 37

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)

□Physical	□Cholesterol	□Prostate	□Blood (which?)
□HIV/STD	□Pap smear	□Mammography	□Other:_____

Test Results and Date:_____

Check any you have had in the past:

□Diabetes	□Allergies	□Glaucoma	□Rheumatic Fever
□Heart Disease	□CVA (stroke)	□Vein condition	□Thyroid disorder
□Asthma	□Pneumonia	□Tuberculosis	□Emphysema
□Jaundice	□Gonorrhea	□Mumps	□Bleeding tendency
□Syphilis	□Measles	□Chicken pox	□Nervous disorder
□Meningitis	□HIV	□Polio	□Mononucleosis
□Epilepsy	□High fever	□Hepatitis	□Multiple Sclerosis
□Paralysis	□Cancer	□Migraines	□High blood pressure
□other lung illnesses	□other liver illnesses	□other heart illnesses	□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):

<u>Overall Temperature (Kidney function)</u>:
□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_____

<u>Overall energy (Lung, Kidney function)</u>:
□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_____

<u>Eyes (Liver function)</u>:
□Itchy
□Bloodshot
□Hot
□Dry
□Watery
□Gritty
□Blurry vision
□Decreased night vision
□Near-sighted
□Far-sighted
□Others_____

<u>Kidney, Urinary Bladder function</u>:
□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? □Y □N
Number of children:_____
Age of first menstruation:_____
Average number of days of flow:_____
□Vaginal discharge

Pregnant? □Y □N
Number of pregnancies:_____
Age of menopause (if applicable):_____
Average number of days of entire cycle:_____
□Bleeding between periods

□Others_____

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

□nausea □vomiting □water retention □breast swelling
□food cravings □headaches □migraines □breast tenderness
□depression □irritability □anxiety □other emotions:_____
□dull pain, where?_____ □sharp pain, where?_____

□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:_____