

## New Patient Information

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Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Street Address \_\_\_\_\_ Unit \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Preferred Phone \_\_\_\_\_ Email \_\_\_\_\_  
Birth Date (include year) \_\_\_\_\_ Age \_\_\_\_\_  
Gender \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Marital Status \_\_\_\_\_ Referred by \_\_\_\_\_  
Emergency Contact: Name \_\_\_\_\_ Phone \_\_\_\_\_  
Primary Care Physician: Name \_\_\_\_\_ Phone \_\_\_\_\_  
Other Practitioners Involved In Your Care:  
Name \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Phone \_\_\_\_\_

### Fees:

It is our policy that you pay the entire session fee or co-pay at the time of each session. We will provide a minimum of one month's notice of any changes to our fees.

Insurance Company \_\_\_\_\_

Insurance Company Phone Number (Provider Line) \_\_\_\_\_

ID # \_\_\_\_\_

Please bring a photocopy of your insurance card (front and back) **or** bring your card to your first appointment so we can make a copy at the clinic.

### Cancellation Policy:

If you need to change or cancel your appointment please notify us within a minimum of 24 hours notice. Failure to do so will result in being charged the equivalent of the cash rate of the missed appointment to your account.

I understand the cancellation policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Health History:**

Have you had acupuncture before? \_\_\_\_\_ If so, for what reason? \_\_\_\_\_

Main issue(s) you are seeking treatment for and length of time experiencing each: \_\_\_\_\_

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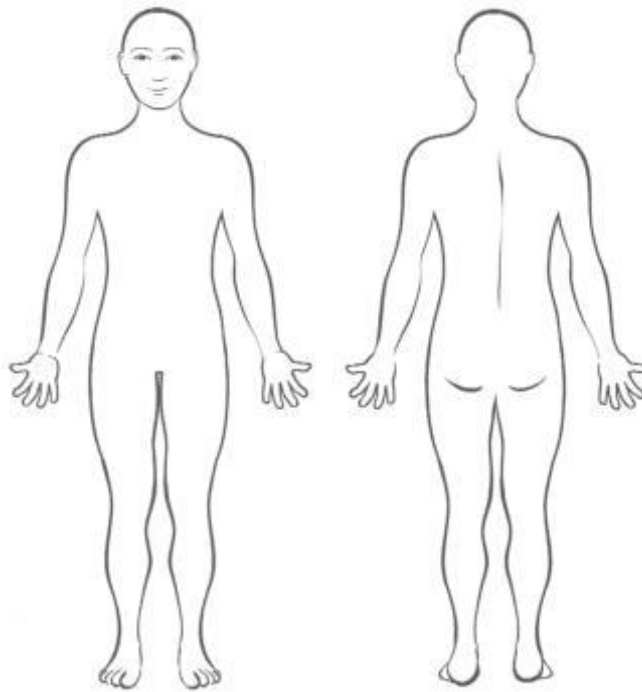
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Diagnoses from a medical professional and approximate dates of diagnosis (if applicable):

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**Please mark any areas of pain or discomfort:**

**Please list areas of pain or discomfort below with the 1-10 pain scale and a brief history:**

(1: barely noticeable pain, 10: excruciating pain)

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**Please check any symptoms that you have experienced in the past or currently experience:**

**General**

	<b>past</b>	<b>current</b>		<b>past</b>	<b>current</b>
sweating easily during the day	<input type="checkbox"/>	<input type="checkbox"/>	loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>
weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	increase in appetite	<input type="checkbox"/>	<input type="checkbox"/>
brain fog or confusion	<input type="checkbox"/>	<input type="checkbox"/>	trouble falling asleep	<input type="checkbox"/>	<input type="checkbox"/>
dizziness/vertigo	<input type="checkbox"/>	<input type="checkbox"/>	trouble staying asleep	<input type="checkbox"/>	<input type="checkbox"/>
fatigue during the day	<input type="checkbox"/>	<input type="checkbox"/>	swollen/sore lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
fevers	<input type="checkbox"/>	<input type="checkbox"/>	bleed or bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
chills	<input type="checkbox"/>	<input type="checkbox"/>	autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>

*Please elaborate:*

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**Skin & Hair**

	<b>past</b>	<b>current</b>		<b>past</b>	<b>current</b>
rashes/hives	<input type="checkbox"/>	<input type="checkbox"/>	psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
eczema	<input type="checkbox"/>	<input type="checkbox"/>	itchy skin	<input type="checkbox"/>	<input type="checkbox"/>
dry skin	<input type="checkbox"/>	<input type="checkbox"/>	acne	<input type="checkbox"/>	<input type="checkbox"/>
oily skin	<input type="checkbox"/>	<input type="checkbox"/>	loss of hair/thinning hair	<input type="checkbox"/>	<input type="checkbox"/>

*Please elaborate:*

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**Head, Ears, Eyes, Nose & Throat**

	<b>past</b>	<b>current</b>		<b>past</b>	<b>current</b>
earaches/pressure in the ears	<input type="checkbox"/>	<input type="checkbox"/>	headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>
ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>	sinus pressure	<input type="checkbox"/>	<input type="checkbox"/>
hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
eye floaters	<input type="checkbox"/>	<input type="checkbox"/>	dizziness/vertigo	<input type="checkbox"/>	<input type="checkbox"/>
itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	teeth/jaw clenching	<input type="checkbox"/>	<input type="checkbox"/>
blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	sore throat	<input type="checkbox"/>	<input type="checkbox"/>
vision loss	<input type="checkbox"/>	<input type="checkbox"/>	swollen throat	<input type="checkbox"/>	<input type="checkbox"/>

*Please elaborate:*

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### **Cardiovascular/Circulatory**

	<b>past</b>	<b>current</b>		<b>past</b>	<b>current</b>
chest pain	<input type="checkbox"/>	<input type="checkbox"/>	swelling/edema	<input type="checkbox"/>	<input type="checkbox"/>
fainting	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>	low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
cold hands & feet	<input type="checkbox"/>	<input type="checkbox"/>	palpitations	<input type="checkbox"/>	<input type="checkbox"/>
heart arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>			

*Please elaborate:*

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### **Respiratory**

	<b>past</b>	<b>current</b>		<b>past</b>	<b>current</b>
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anxiety	<input type="checkbox"/>	<input type="checkbox"/>	poor memory	<input type="checkbox"/>	<input type="checkbox"/>
depression	<input type="checkbox"/>	<input type="checkbox"/>	quick temper	<input type="checkbox"/>	<input type="checkbox"/>
loss of balance/coordination	<input type="checkbox"/>	<input type="checkbox"/>	easily susceptible to stress	<input type="checkbox"/>	<input type="checkbox"/>
areas of numbness/paralysis	<input type="checkbox"/>	<input type="checkbox"/>	mood swings	<input type="checkbox"/>	<input type="checkbox"/>
irritability	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Parkinsons	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>

*Please elaborate:*

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**Digestive**

	<b>past</b>	<b>current</b>		<b>past</b>	<b>current</b>
heartburn	<input type="checkbox"/>	<input type="checkbox"/>	gas	<input type="checkbox"/>	<input type="checkbox"/>
belching	<input type="checkbox"/>	<input type="checkbox"/>	diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
bloating	<input type="checkbox"/>	<input type="checkbox"/>	constipation	<input type="checkbox"/>	<input type="checkbox"/>
nausea	<input type="checkbox"/>	<input type="checkbox"/>	abdominal pain/cramps	<input type="checkbox"/>	<input type="checkbox"/>
vomiting	<input type="checkbox"/>	<input type="checkbox"/>	mucus in stool	<input type="checkbox"/>	<input type="checkbox"/>
chronic bad breath	<input type="checkbox"/>	<input type="checkbox"/>	blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
sores on lips/tongue	<input type="checkbox"/>	<input type="checkbox"/>	hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>

*Please elaborate:*

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**For Women Only:**

	<b>past</b>	<b>current</b>		<b>past</b>	<b>current</b>
irregular periods	<input type="checkbox"/>	<input type="checkbox"/>	breast pain	<input type="checkbox"/>	<input type="checkbox"/>

painful periods	<input type="checkbox"/>	<input type="checkbox"/>	vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>
bleeding between periods	<input type="checkbox"/>	<input type="checkbox"/>	vaginal sores	<input type="checkbox"/>	<input type="checkbox"/>
period clots	<input type="checkbox"/>	<input type="checkbox"/>	hot flashes	<input type="checkbox"/>	<input type="checkbox"/>
menstrual cramping	<input type="checkbox"/>	<input type="checkbox"/>	night sweating	<input type="checkbox"/>	<input type="checkbox"/>

age of first menses \_\_\_\_\_ duration of typical period \_\_\_\_\_

duration of typical cycle \_\_\_\_\_ date of last PAP \_\_\_\_\_

# of pregnancies \_\_\_\_\_ # of live births (+ years) \_\_\_\_\_

# of miscarriages \_\_\_\_\_ # of abortions \_\_\_\_\_

**Are you currently pregnant or breastfeeding?** \_\_\_\_\_

Have you been through menopause? Age? \_\_\_\_\_

Did you experience a difficult menopause?

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Have you ever taken birth control pills? When and for how long? \_\_\_\_\_

Other premenstrual & menstrual symptoms (bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.)

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*Please elaborate on any of the above:*

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**For Men Only:**

	<b>past</b>	<b>current</b>		<b>past</b>	<b>current</b>
erectile dysfunction/impotence	<input type="checkbox"/>	<input type="checkbox"/>	ejaculatory pain	<input type="checkbox"/>	<input type="checkbox"/>

varicocele

BPH

*Please elaborate:*

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**Lifestyle:**

Current medications/herbs/supplements (please list dosages and how long you have been taking each):

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Do you follow any certain diet or way of eating? (vegetarian, gluten-free, paleo, etc.)

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How much water do you drink per day? Is it filtered and if so, which type of filter do you use?

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Have you used antibiotics in the past? If so, when and how often?

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Current exercise routine:

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Do you or have you ever used tobacco? If so, how often?

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Do you or have you ever drank alcohol heavily? If so, how many drinks/week?

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Do you or have you ever taken recreational drugs? If so, how often?

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Are you currently taking any of the following medications? (*circle if yes and indicate how often*)

Advil/Motrin/Ibuprofen

Aleve/Naproxen

Prednisone/Prednisolone

Celebrex/Celecoxib

Bayer/Aspirin

Acetaminophen/Tylenol

Allergies (medications/foods/chemicals/etc.):

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Have you ever had a seizure? If yes, indicate date of last: \_\_\_\_\_

**Please circle any significant illnesses and indicate date:**

Cancer

Hepatitis

Diabetes

High blood pressure

Epilepsy

Heart Attack

Stroke

Ulcer Disease

Liver Disease

Colon Polyps

Other \_\_\_\_\_

Please list any major surgeries/hospitalizations and approximate dates:

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**Family Medical History:**

Cancer     Seizures     High blood pressure     Stroke     Diabetes

Heart Attack     Hepatitis     Asthma     Other \_\_\_\_\_

**What are your goals for your health?**

**Please list any other relevant information or issues you would like to discuss:**

*Thank you for taking the time to fill out these forms. Please let us know if you have any questions or concerns.*

### **Informed Consent for Acupuncture Treatment and Care**

I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by Doweon Park DACM,L.Ac.

I understand that methods or treatment may include, but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, PEMF, Tui-Na (Chinese Massage), Chinese or Western herbal medicine, supplement recommendations, and nutritional counseling.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

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 Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment during the course of the procedure, which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my consent. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

I understand my patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by my authorization, or when required or permitted by law.

By signing below, I agree to the above- named procedures. 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's Name \_\_\_\_\_

Patient's/Patient Representative's Signature \_\_\_\_\_

Today's Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_