|  |  |
| --- | --- |
|  | **Anita Lang-Bakar, L.Ac.**  3727 Buchanan Street, Suite 204  San Francisco, CA 94123  415-570-1527  www.driftwoodacu.com |

**Patient Medical History & Intake Form**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date \_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_\_\_\_\_\_\_\_ How would you like to be addressed?

□ Single □ Married □ Divorced □ Widowed □ Domestic Partnership □ Other

Referred to out Clinic by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment:** Please check all that apply

□ Full-time □ Part-time □ Self-employed □ Student □ Unemployed □ Retired

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of hours of work/study per week \_\_\_\_\_\_\_\_

Employer’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Billing and Insurance** Account Paid by □ Self □ Workmen’s Comp □ Other

Primary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy# / ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had an acupuncture treatment? When and for what reason?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you presently being treated for a medical condition? Please describe.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What health issue(s) do you want to be treated for? Please describe as fully as possible.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What treatment (if any) have you been using for relief of this issue?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have other health concerns? If so, please describe.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please describe the types of foods you eat regularly at each meal and during the day:**

Breakfast \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dinner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snacks/other meals \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you Exercise Regularly? □ Yes □ No How Frequently?\_\_\_\_\_\_\_\_\_\_ times per day / week

What type of Exercise do you do?

**Let us know how you feel about the following areas of your life. Please mark the appropriate description and indicate any problems you may be experiencing:**

Spouse/Partner □ Great □ Good □ Fair □ Poor □ Bad \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family □ Great □ Good □ Fair □ Poor □ Bad \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diet □ Great □ Good □ Fair □ Poor □ Bad \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex □ Great □ Good □ Fair □ Poor □ Bad \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Self □ Great □ Good □ Fair □ Poor □ Bad \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work □ Great □ Good □ Fair □ Poor □ Bad \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History -** Please check **all** that are appropriate by marking with an X

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Self | Mother | Father | Sister | Brother | Child | Grandparent |
| Allergies |  |  |  |  |  |  |  |
| Blood disorder/Anemia |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |
| Cancer or Tumors |  |  |  |  |  |  |  |
| Seizures |  |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |  |
| Kidney or Bladder disorder |  |  |  |  |  |  |  |
| Stomach or intestinal disorder |  |  |  |  |  |  |  |
| Drug Abuse |  |  |  |  |  |  |  |
| Tuberculosis |  |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |
| Depression/Mental Illness |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |
| Age at death |  |  |  |  |  |  |  |

**Habits -** Please check any habits that apply to you now or in the past

Coffee □ Yes □ No cups per day/week: age started \_\_\_\_ age quit \_\_\_\_

Tobacco □ Yes □ No cigarettes per day/week: age started \_\_\_\_ age quit \_\_\_\_   
Alcohol □ Yes □ No Drinks per day/week: age started \_\_\_\_ age quit \_\_\_\_

Cocaine □ Yes □ No use per day/week \_\_\_\_ age started \_\_\_\_ age quit \_\_\_\_

Heroin □ Yes □ No use per day/week \_\_\_\_ age started \_\_\_\_ age quit \_\_\_\_   
Marijuana □ Yes □ No use per day/week \_\_\_\_ age started \_\_\_\_ age quit \_\_\_

Other:

**Major Hospitalizations -** Please list any hospitalizations or surgeries you have undergone.

|  |  |  |  |
| --- | --- | --- | --- |
| **Year** | **Operation or illness** | **Name of Hospital** | **City & State** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Medicines, Herbs and Supplements** - Check any medications you are currently taking

# □ Aspirin □ Ibuprofen (Advil) □ Acetaminophen (Tylenol)

# □ Antacids □ Laxatives □ Cold tablets □ Allergy Medicine

# □ Diet Pills □ Tranquilizers □ Sleeping Pills □ Oral contraceptives

# □ Blood pressure Pills □ Blood thinning medication □ Insulin/diabetes pills □ Fiber Supplements

□ Other: (Please List name of drug & Dosage)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vitamins & Supplements** (Please List)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Herbs** (Please List)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

✚✚ **Allergies** □ Yes □ No

To Medication:

To Food:

Latex or other:

**Additional Information:**

**Symptoms/Concerns** Please mark all that apply

**Musculo-Skeletal**

**Injury**

□ Past □ Current: Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Joint Pain**

□ Past □ Current: Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Muscular Pain**

□ Past □ Current: Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Strain**

□ Past □ Current: Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Broken Bone(s)**

□ Past □ Current: Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Atrophy**

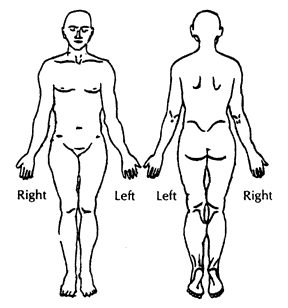
□ Past □ Current: Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Localized Weakness**

□ Past □ Current: Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Numbness/Tingling of Limbs**□ Past □ Current: Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Area of Pain (Please circle the area of concern)**



**Explanation of Pain:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Quality of Pain:** (circle appropriate)

**Sharp - shooting / dull - achy**

**Cause: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Worse with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Better with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you seen a specialist?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Lab tests / X-Ray / MRI /Scan (circle)**

**Date:**

**Medication you’ve been given for this condition:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Better / unchanged / worse (Circle one)**

**General**  ***(Check box or circle when applicable)***

**Overall energy** Good Fair Poor

Time of day when lowest?

**Body temperature**

□ tend to run cold □ tend to run warm

□ Cold hands □ Cold feet

□ Sweats easily □ Night sweats

□ Chills □ Fevers

Past Current

**□ □** Increased Appetite

**□ □** Decreased appetite

**□ □** Weight Gain / Loss

Food Cravings: Sweet Sour Salty Spicy

**□ □** Strong thirst

**□ □** Lack of thirst

Preference: Cold Warm Hot Room Temp

□ □ Eating disorder

**Sleep**

Good Fair Poor Average hours of sleep:

Past Current

**□ □** Difficulty Falling asleep

**□ □** Difficulty staying asleep

**□ □** Get up to go to bathroom (# )

**□ □** Vivid Dreams

**□ □** Insomnia

**□ □** Sleep Apnea

**□ □** Clench Jaw / Grind teeth (Mouth guard?)

**Psychological**

Past Current

□ □ Depression

□ □ Anxiety / Stress

□ □ Panic Attacks

□ □ Irritability / Anger

□ □ Addictions

To what:

□ □ Treated for Emotional / Psychological Issues

For what:

**Head & Neck**

Past Current

**□ □** Concussion / Whiplash (date\_\_\_\_\_\_\_)

**□ □** Dizziness / Fainting / light headed

**□ □** Neck stiffness

**□ □** Enlarged lymph nodes

**□ □** Poor Memory / difficulty concentrating

**□ □** RecurrentHeadaches / migraines

**Eyes**

Past Current

**□ □** Glasses / Contacts

**□ □** Redness / itching / tearing

**□ □** Floaters / spots

**□ □** cataracts / Glaucoma / Macular degeneration

**□ □** Poor vision (near or Far)

**□ □** Blurred vision / Poor night vision

**Ears**

Past Current

**□ □** Infections – recurring?

**□ □** Ringing (High pitched or Low pitched)

**□ □** Decreased Hearing

**Skin & Hair**

Past Current

**□ □** Rashes / Hives

**□ □** Acne / Pimples

**□ □** Dry skin / oily skin

**□ □** Bruise easily

**□ □** Eczema

**□ □** Psoriasis

**□ □** Shingles / Herpes 1 or 2

**□ □** Tumors, Lumps/ Cysts (Location\_\_\_\_\_\_\_\_\_\_\_)

**□ □** Hair loss (sudden?)

**Nose, Throat & Mouth**

Past Current

**□ □** Nosebleeds

**□ □** Sinus Infections

**□ □** Hay Fever / Allergies

**□ □** Gum / Teeth problems

**□ □** Difficulty Swallowing

**□ □** Frequent Sore throats

**□ □** Dry Mouth or Throat

**□ □** Hoarse voice

**Respiratory**

Past Current

**□ □** Asthma / Bronchitis

**□ □** Frequent Colds

**□ □** COPD / Emphysema / Pneumonia

**□ □** Chronic cough (dry or productive)

**□ □** Coughing blood

**Cardiovascular**

Past Current

**□ □** High / Low Blood Pressure

**□ □** High cholesterol

**□ □** Phlebitis / vein inflammation

**□ □** Blood clots

**□ □** Palpitations

**□ □** Irregular Heart beat (non anxiety related)

**□ □** Chest Pain / Pressure (rest or exertion)

**□ □** Poor circulation

**□ □** Swelling of hands / feet

**Neurological**

Past Current

**□ □** Seizures

**□ □** Tremors (Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**□ □** Numbness or tingling of limbs

**□ □** Pain

**□ □** Paralysis

**Gastro-intestinal**

Past Current

Bowel Movements: Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Diarrhea (chronic or alternating)

□ □ Constipation (chronic or alternating)

□ □ Frequent indigestion

□ □ Flatulence (gas) / Belching

□ □ Acid reflux / GERD

□ □ Nausea / Vomiting

□ □ Pain or cramps (location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

□ □ Blood in stools

□ □ Pale or black stools

□ □ Rectal pain / hemorrhoids

□ □ IBS / Chron’s / Ulcerative colitis

□ □ Ulcers

□ □ Bad Breath

**Genito- Urinary**

Past Current

□ □ Frequent urination

□ □ Urgency

□ □ Unable to Hold / incontinence

□ □ Pain with urination

□ □ Blood in urine

□ □ Weak urine stream

□ □ Kidney Stones

□ □ UTI’s

**Male**

Past Current

□ □ Impotence

□ □ Premature Ejaculation

□ □ Testicular lumps / masses

□ □ Benign Prostatic Hyperplasia

□ □ Genital itching / pain

□ □ Genital Lesions or discharge

□ □ Weak Urinary Stream

□ □ Decreased / Excessive Libido

**Infection Screening** (Positive Test)

Past Current

□ □ HIV / TB

□ □ Hepatitis

□ □ Gonorrhea / Syphillis

□ □ Genital Warts or HPV

□ □ Herpes – Oral or Genital

**Female**

Past Current

□ □ Irregular Periods

□ □ Painful Periods / cramps

□ □ PMS symptoms

(Breast tenderness / Lower Back pain/, irritability weepiness/ moodiness)

□ □ Urinary Tract Infections (UTI’s)

□ □ Vaginal or Yeast Infections

□ □ Genital Pain or itching

□ □ Genital Lesions or discharge

□ □ Pelvic Inflammatory Disease (PID)

□ □ Abnormal bleeding / spotting

□ □ Breast Lumps / pain

□ □ Abnormal Pap Smear (date\_\_\_\_\_\_\_\_)

□ □ Decreased or Excessive Libido

Date of Last Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typical duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Change in BM’s before?

Color? Clots ?

**Pregnancies**

Total Pregnancies\_\_\_\_\_\_\_\_Living\_\_\_\_\_

Ectopic \_\_\_\_\_\_\_ # Miscarriages\_\_\_\_\_

# Abortions\_\_\_\_\_

Age of onset of Menses \_\_\_\_\_

Age of onset of Menopause \_\_\_\_\_

□ □ Menopausal Syndrome

- Date of Last Period:

- Hormone replacement Therapy:

**Patient Treatment Informed Consent Agreement**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby give my consent for ***Anita Lang-Bakar, L.Ac with Driftwood Acupuncture & Wellness*** to perform treatment utilizing Traditional Chinese Medicine techniques.

I understand that the techniques utilized in Chinese Medicine and by Driftwood Acupuncture & Wellness are not experimental, but backed by over 3 thousand years of clinical experience in China and used successfully in the West.

These practices are accepted therapy recognized by the State of California. The methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (Chinese Massage), Guasha (scraping technique), Chinese Herbal Medicine, and nutritional counseling.

I understand that all acupuncture or other Traditional Chinese treatments will be performed by a CA State licensed acupuncturist.

I understand that all needles utilized for the acupuncture treatments are pre-packaged, sterile, single-use needles that have never before been used and will be discarded after each treatment.

Although the clinic uses sterile, disposable needles and maintains a clean and safe environment, infection is another possible risk of treatment. Risks associated with moxibustion treatment may include burns and/or scarring, although unusual and rare. I understand that while this document describes major risks of treatment, other unanticipated side effects may occur. I do not expect the acupuncturist to be able to anticipate all possible complications from treatment, but I do wish to rely on the acupuncturist to exercise judgment during the course of treatment, which based upon the facts known and my condition, is in my best interests.

Initial \_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are safe in the practice of Chinese Medicine, although some may be toxic if not taken as prescribed. Other possible side effects of herbal treatments are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that some herbs may be inappropriate during pregnancy.

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided verbally and in writing. The herbs may have an unpleasant taste or smell. I will immediately notify my practitioner of any unpleasant effects associated with the consumption of herbal teas or products.

**• I will notify Anita Lang-Bakar**, **L.Ac if I am or become pregnant.**

**• I will notify Anita Lang-Bakar**, **L.Ac if I change any of my Medications or start taking new ones.**

**• I agree to follow all treatments only as recommended/prescribed. If I am experiencing any side effects or difficulties I will notify practitioner as soon as possible.**

Initial \_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Privacy Policy**

I understand that the clinical and medical staff may review my files but all my records will be kept confidential and can only be released under my personal written consent or when required by law.

Initial \_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cash and Personal Insurance Financial Agreement

- You are financially responsible for all services rendered to you in this office.

- Payment is made in full (100%) for each visit at the time of visit unless special arrangements have been made with your provider.

- If using insurance, you are responsible for your co-pay as well as for payments for services that your insurance carrier may determine non-covered, excluded, unreasonable, or not medically necessary.

I understand all of the above and acknowledge that if I use insurance, **I will be charged 7$** by Driftwood Acupuncture to file each claim.

Initial \_\_\_\_\_\_\_\_\_\_\_\_

**Cancellation Policy**

- No charge will be made for cancellations or appointment changes if 48 hours notice is given.

- For cancellations with less than 48 hours notice the full price of your appointment will be charged.

- Monday appointments need to be cancelled by 5pm on Friday afternoons.

**I hereby certify that I have read (or have had it read to me) and understand the above consent form.**

**This consent form shall cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment. I may have a copy of this form for my records.**

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

(Patient/Representative)

Clinician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Anita Lang-Bakar, L.Ac.)