

Thank you for coming. Please help us to provide you with a complete evaluation by taking the time to fill out this questionnaire. All your information will be confidential. If you have questions please ask. Thank you.

PATIENT INFORMATION

Date _____

Name _____

Address _____

City State Zip

Sex: ☐ M ☐ F Age _____ Birthdate _____

☐ Single ☐ Married ☐ Significant Other
☐ Widowed ☐ Separated ☐ Divorced

Number of Children _____

Phone # _____ Alternative # _____

Best time & place to reach you _____

Email address _____

Patient SS# _____

Occupation _____

Employer _____

Emp. Address _____

Emp. Phone _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home phone _____ Work phone _____

GENERAL INFORMATION

How did you find out about us? _____

Have you had acupuncture before? ☐ Yes ☐ No

Have you used Chinese herbal medicine? ☐ Yes ☐ No

Are you currently under the care of a physician?
☐ Yes ☐ No If Yes, for what? _____

Physician's name _____

Physician's phone _____

Allow email/mail/phone/text/kakaotalk contact? Y ☐ N ☐

INSURANCE

Who is responsible for this account? _____

Primary Insurance Company _____

ID # _____

Group # _____

Name of Insured _____

Relationship to Patient: Self ☐ Spouse ☐ Parent ☐

Primary Insurance Company _____

ID # _____

Group # _____

Name of Insured _____

Relationship to Patient: Self ☐ Spouse ☐ Parent ☐

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship Date

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

Contact # _____

INFORMED CONSENT TO ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or one of the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand that the methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (Chinese therapeutic massage), therapeutic massage, Chinese herbal medicine, nutritional supplements, nutritional counseling, and essential oil therapy and all are generally safe methods of treatments.

I have been informed that acupuncture is generally a safe method of treatment, but that it may have some side effects. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture -- including lung puncture (pneumothorax). Infection is another possible risk, although in JP Acupuncture & Wellness uses sterile, single use needles and maintains a clean and sterile environment.

Herbal and nutritional supplements recommended to me by the acupuncturist are safe in recommended doses. Large doses of herbs taken without my practitioner's recommendations may be toxic, and some herbs are inappropriate when taken during pregnancy. Some possible side effects of herbs and nutritional supplements are nausea, gas, stomach aches, vomiting, headaches, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs or supplements and notify the acupuncturist as soon as I experience any discomfort or adverse reaction. I further understand that I must inform the acupuncturist if I am or start taking any medication or herbal/ supplements from another source.

I will notify the acupuncturist if I become pregnant or am in the process of trying to become pregnant.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and 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.

To be completed by patient:

To be completed by patient's representative, if necessary, e.g., if patient is a minor or physically or legally incapacitated:

Print Patient's Name

Print Name of Patient

Signature of Patient

Signature of Patient's Representative

Date Signed

As: Relationship or authority of Patient's Representative

Date Signed

To be completed by acupuncturist or staff:

Name and address of clinic/office:

Print name(s) of acupuncturist(s) treating this patient:

JP Acupuncture & Wellness

Joshua Pak, L.Ac.

3816 Woodruff Ave. Suite 205

Long Beach, CA 90808

Current Health & Lifestyle

Do you exercise? Y ☐ N ☐ If yes, how many times per week? Please Describe.
Height: Weight: Now One year ago Maximum in Year
How many hours do you sleep at night (average)? When do you usually go to bed?

Medications and Supplements

Medications you are currently taking (please include prescription medicines, vitamins, supplements, over the counter drugs, herbal supplements, etc.):

Past Medical History

Check any conditions that you have had in the past or are currently experiencing: **P=Past C=Current**

P	C		P	C		P	C		P	C	
☐	☐	Arthritis	☐	☐	Digestive Disorder	☐	☐	Kidney Disease	☐	☐	Migraines
☐	☐	Asthma	☐	☐	Heart Disease	☐	☐	Liver Disease	☐	☐	Nervous Disorder
☐	☐	Cancer	☐	☐	High Cholesterol	☐	☐	Mental Illness	☐	☐	Stroke
☐	☐	Diabetes	☐	☐	Hypertension	☐	☐	Other:			

Profile

Please check any of the following symptoms that **currently** pertain to you.

General

☐ Cold hands	☐ Hot body temperature	☐ Profuse perspiration	☐ Chills
☐ Cold feet	☐ Cold body temperature	☐ Lack of perspiration	☐ Fever
☐ Sweaty hands	☐ Afternoon flushing	☐ Perspire easily	☐ Strong thirst
☐ Sweaty feet	☐ Hot flashes	☐ Night sweating	☐ Knee soreness
☐ Dizziness	☐ Hearing loss	☐ Knee soreness	☐ Cold knees
☐ Dizziness	☐ Ringing in ears/tinnitus	☐ Knee soreness	☐ Cold Feet

Emotions

☐ Mood swings	☐ Anxiety	☐ Depression	☐ Fear
☐ Sadness	☐ Panic attacks	☐ Nervousness	☐ Frequent worrying
☐ Nervousness	☐ Irritability	☐ Anger	☐ Easily stressed

Cardiovascular

☐ Heart palpitations	☐ Chest Pain/Angina	☐ Tongue ulcers	☐ Speech impediment
☐ Restless dreams	☐ Mental restlessness	☐ Insomnia	☐ Hallucinations

Respiratory

☐ Persistent cough	☐ Nasal dryness	☐ Chest congestion	☐ Shortness of breath
☐ Sinus congestion	☐ Chronic allergies	☐ Sneezing	☐ Difficulty Breathing

Gastrointestinal

☐ Indigestion	☐ Low or weak appetite	☐ Fatigue following a meal	☐ Nausea/Vomiting
☐ Acid reflux	☐ Gurgling in intestines	☐ Easily fatigued	☐ Vomiting
☐ Stomach ache	☐ Bruise easily	☐ Gas	☐ Constipation
☐ Loose stools	☐ Blood in stools	☐ Belching	☐ Diarrhea

Lymphatic System/Accumulated Dampness

☐ Swollen hands	☐ Mental fogginess	☐ Edema in the legs	☐ Heavy limbs/head
☐ Swollen feet	☐ Mental sluggishness	☐ Edema in the abdomen	☐ Joint stiffness

Urinary

☐ Cloudy	☐ Small amount	☐ Night-time urination	☐ Incontinence
☐ Dark yellow	☐ Large amount	☐ Difficulty initiating urination	☐ Strong odor
☐ Clear color	☐ Dribbling	☐ Very frequent	☐ Pain or burning

Major Health Complaint(s)

Please list in order of significance to you and **check** which you would like us to focus on today.

- | | | | |
|-----------------------------|--------------------------|-----------------------------|--------------------------|
| 1. ☐ | ☐ | 4. ☐ | ☐ |
| 2. ☐ | ☐ | 5. ☐ | ☐ |
| 3. ☐ | ☐ | 6. ☐ | ☐ |

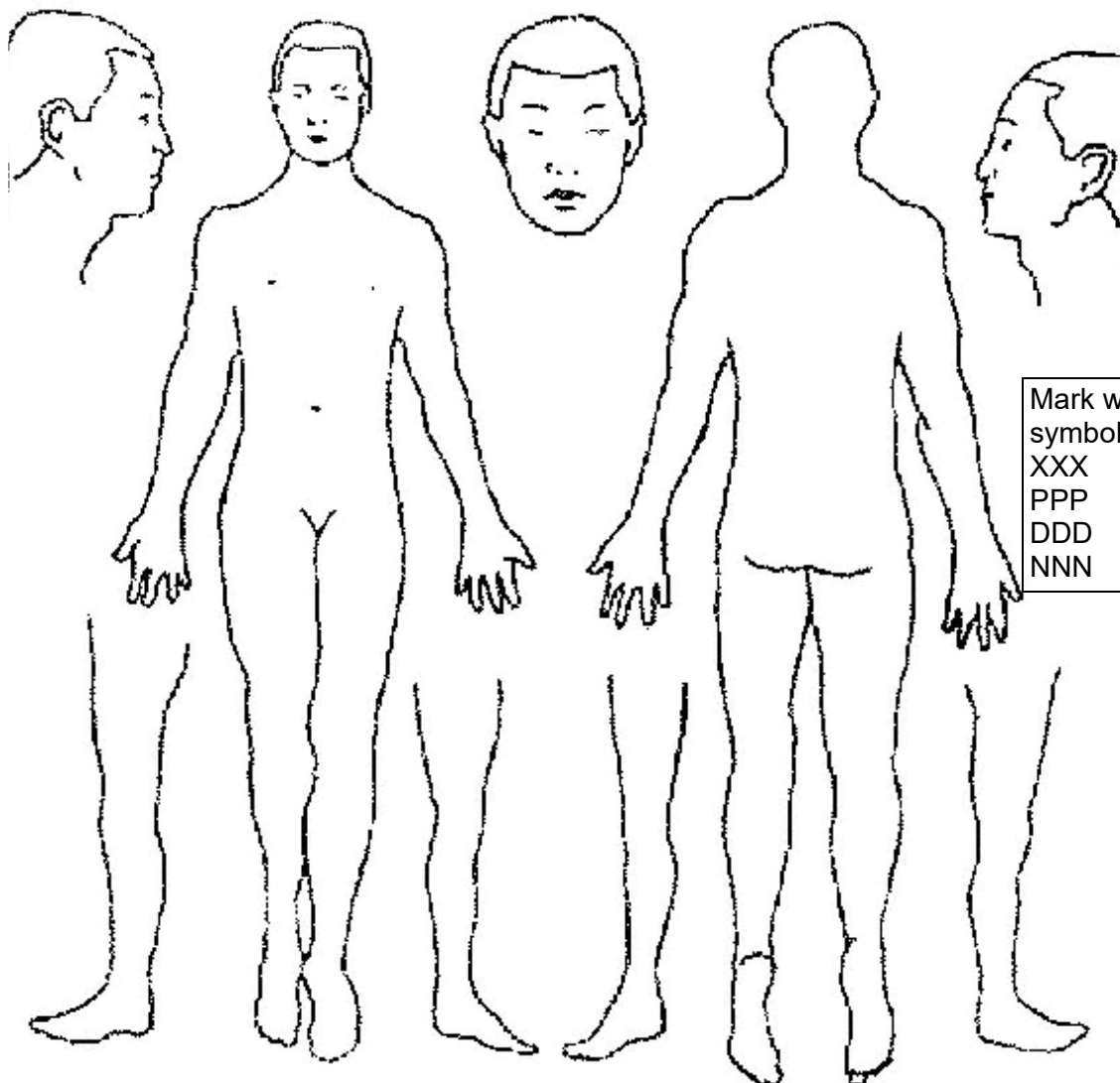
When did the checked problem begin?

Have you been given a diagnosis for this problem? If so, please describe.

What kind of treatments have you tried?

What makes this problem worse? Better?

Please indicate painful or distressed areas by using the symbol that best describes the feeling:



Mark with appropriate symbols:
 XXX Sharp / Stabbing
 PPP Pins and Needles
 DDD Dull / Aching
 NNN Numbness

Please rate your **current** level of pain: Very mild 1 2 3 4 5 6 7 8 9 10 Very severe
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Patient Printed Name:

Patient Signature