

Patient Information
Liat Barnea M.S., L.Ac.

Patient's Name _____ Today's Date _____

Street Address _____ City, State _____

Zip _____ Cell Phone (____) _____ Place of birth _____

Email _____ Birth Date _____ Age ____ Gender _____

Referred by _____

Emergency Contact _____ Relationship _____

Emergency Contact Cell #(____) _____

Physician's Name _____ Phone(____) _____

Date of last visit _____

Employment – Please check all that apply

full-time part-time self-employed unemployed retired

Occupation _____ # hours work/study per week _____

Employer's Name _____ Phone(____) _____

Billing

Payment in full is due at the time services are rendered. Office visits are \$90, with an additional \$30 fee for the first visit. Please allow up to 2 hours for the first visit, and approximately one hour for each visit thereafter.

Missed Appointment Policy

If you need to change or cancel your appointment please do so with 24 hours notice. Failure to do so will result in being charged for the full fee of the appointment.

____ I understand cancellation policy (please initial)

Insurance Company Name _____ Patient's Subscriber ID _____

Main Subscriber Name: _____

Main Subscriber ID _____ Main Subscriber Date of Birth _____

Confidentiality

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

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Health History

Patient Name _____ Date _____

Have you had acupuncture treatment before? If so, for what reason(s)?

Pain

Circle **L** for left and **R** for right side of body, or circle both where applicable

- | | | | | | | | |
|------------------------------------|-----|------------------------------------|-----|-------------------------------------|-----|--------------------------------|-----|
| <input type="checkbox"/> Head | L R | <input type="checkbox"/> Forearm | L R | <input type="checkbox"/> Upper back | L R | <input type="checkbox"/> Shin | L R |
| <input type="checkbox"/> Jaw | L R | <input type="checkbox"/> Wrist | L R | <input type="checkbox"/> Mid-back | L R | <input type="checkbox"/> Ankle | L R |
| <input type="checkbox"/> Neck | L R | <input type="checkbox"/> Hand | L R | <input type="checkbox"/> Low back | L R | <input type="checkbox"/> foot | L R |
| <input type="checkbox"/> Throat | L R | <input type="checkbox"/> Fingers | L R | <input type="checkbox"/> Hip | L R | <input type="checkbox"/> Heel | L R |
| <input type="checkbox"/> Shoulder | L R | <input type="checkbox"/> Chest | L R | <input type="checkbox"/> Thigh | L R | <input type="checkbox"/> Toes | L R |
| <input type="checkbox"/> Upper arm | L R | <input type="checkbox"/> Rib/flank | L R | <input type="checkbox"/> Knee | L R | | |
| <input type="checkbox"/> elbow | L R | <input type="checkbox"/> abdomen | L R | <input type="checkbox"/> Calf | L R | | |

Stomach/Spleen

- | | | |
|------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Recurring sore throat | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Belching/burping | <input type="checkbox"/> Laryngitis/hoarse voice | <input type="checkbox"/> Edema (swelling) |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Gas | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Abdominal bloating | <input type="checkbox"/> Blood or black in stools |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Pus in stools |
| <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> Low energy/fatigue | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Low/no appetite | <input type="checkbox"/> Craving sweets | <input type="checkbox"/> Anal fissures |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Decreased sense of tastes/smell | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Sweet taste in mouth | <input type="checkbox"/> Frequently feel lost in thought |

Lung

- | | | |
|------------------------------------------------|--------------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Asthma | <input type="checkbox"/> Often feel sad |
| <input type="checkbox"/> Sinus infection | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Crave pungent foods |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Dry skin |
| <input type="checkbox"/> Cough with blood | <input type="checkbox"/> COPD | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Production of phlegm | <input type="checkbox"/> Rashes, hives, eczema, or psoriasis | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Hayfever or allergies | | |

Liver

- | | | |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Anxiety/stress | <input type="checkbox"/> Numbness or tingling of limbs |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Eye inflammation | <input type="checkbox"/> Indecisiveness | <input type="checkbox"/> Poor Concentration |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Often feel angry | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Migraines | <input type="checkbox"/> Aversion to wind |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Excessive or vivid dreams | <input type="checkbox"/> Fainting | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Localized weakness | |
| <input type="checkbox"/> Floaters (spots in the visual field) | <input type="checkbox"/> Treated/taken medications for emotional/psychological issues | |

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Kidney

- | | | |
|---------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Frequent urinary tractinfections | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Frequent vaginal infections | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Pelvic inflammatory disease | <input type="checkbox"/> Testicular lumps |
| <input type="checkbox"/> Urine/bowel incontinence | <input type="checkbox"/> Abnormal PAP smear | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Weak urine stream | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Genital itching/pain |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Premenstrual syndrome | <input type="checkbox"/> Genital lesions/discharge |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Painful menstrual periods | <input type="checkbox"/> decreased libido |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> ear ringing - low pitch |
| <input type="checkbox"/> Sore/weak knees | <input type="checkbox"/> Menopause symptoms | <input type="checkbox"/> ear ringing – high pitch |
| <input type="checkbox"/> Crave salty foods | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> decreased hearing |
| <input type="checkbox"/> Often feel afraid | | <input type="checkbox"/> ear infections |

Pregancies: Living _____ Ectopic _____ Miscarriages _____ Abortions _____

Heart

- | | | |
|-----------------------------------------------|----------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Blood clotting disorders |
| <input type="checkbox"/> Low Blood pressure | <input type="checkbox"/> Jaw, neck, shoulder or arm pain | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Nausea | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Swollen hands or feet | <input type="checkbox"/> Crave bitter foods |

Yangming

- | | | |
|----------------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Prefer cold food and drink | <input type="checkbox"/> Prefer warm food and drink |
| <input type="checkbox"/> Frequent or strong thirst | <input type="checkbox"/> Chills | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Tend to feel warmer than others | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Neck stiffness |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Tend to feel colder than others | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Enlarged lymph |

Infectious Diseases

- | | | |
|--------------------------------------|------------------------------------|----------------------------------------------|
| <input type="checkbox"/> HIV | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Genital warts |
| <input type="checkbox"/> TB | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Herpes oral/genital |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> HPV |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Syphilis | |

Other past or current infectious diseases _____

Other current symptoms / motivations for coming for acupuncture: _____

Please describes your health priorities in order of importance:

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Habits – Please check any habits which apply to you now or in the past

Coffee yes no # per day _____ age started _____ age quit _____
 Tobacco yes no # per day _____ age started _____ age quit _____
 Marijuana yes no # per day _____ age started _____ age quit _____
 Alcohol yes no # per day _____ age started _____ age quit _____
 Sugar yes no # per day _____ age started _____ age quit _____
 Prescription yes no # per day _____ age started _____ age quit _____
 drugs

Other relevant habits: _____

Major Hospitalizations Please list any hospitalization or surgeries you have undergone

Year	Operation or Illness	Name of Hospital	City and State

Medicines, Herbs, Supplements that you are currently taking or took very recently

aspirin antacids blood thinners sleeping pills
 ibuprofen fiber/laxatives blood pressure pills tranquilizers
 acetaminophen diet pills insulin
 (Tylenol) allergy medication antidepressants
 oral contraceptives

Other Medications -- please list:

Western Drugs	Herbs	Vitamins and Supplements

Medication Allergies _____

Food Allergies or sensitivities _____

Please describe any restricted diet(s) you follow