Patient Health History

Patient Information

Name:			Home phone:
Preferred Pronoun:			Work phone:
Date:			Cell phone:
Address:			Email:
City:	State:	Zip:	Would you like to be added email newsletter?
Age:	Date of birth:		Yes ☐ No ☐
Occupation:			***Emergency contact***
Company Name:			Name:
Primary care physician:			Relationship:
How did you hear about us?			Phone:

Health History

What are your primary concerns for coming in for treatment?
1)
2)
3)
How is your sleep?
How is your digestion?
How is your energy level overall?
How is your stress level?
When was your last complete medical exam?
List serious illnesses, accidents or surgeries:
1)
2)
3)
List any supplements or medications you are taking:
1)
2)
3)
4)
6)
7)
8)
9)
10)

Check conditions you have or have had in the past:
☐ AIDS/HIV
☐ Allergies
☐ Anemia
☐ Arthritis
☐ Bleeding disorders
☐ Cancer
☐ Diabetes

Check illnesses that have occurred in blood relatives:
☐ Heart Disease
☐ High blood pressure
☐ Kidney Disease
☐ Cancer
☐ Diabetes
☐ Stroke

Check symptoms you have or have had in the last year:
☐ Depression
☐ Difficulty focusing
☐ Dizziness
☐ Easily startled
☐ Excessive worry
☐ Excessive anger
☐ Excessive fear
☐ Fatigue
☐ Headaches
☐ Loss of sleep/poor sleep
☐ Weight gain or loss
☐ Irritability
☐ Anxiety
☐ Feeling overwhelmed

Check symptoms you have or have had in the last year:

Cardiovascular
☐ Chest pain
☐ Hardening of arteries
☐ High or low blood pressure
☐ Poor circulation
☐ Heart attack
☐ Rapid/irregular heart beat
☐ Swelling

Eyes/Ears/Nose/Throat/Respiratory
☐ Asthma
☐ Blurred or failing vision
☐ Difficulty breathing
☐ Earache
☐ Enlarged gland
☐ Eye pain
☐ Frequent colds
☐ Hay fever
☐ Hoarseness
☐ Gum trouble
☐ Nosebleeds
☐ Loss of hearing
☐ Persistent cough
☐ Ringing in ears
☐ Sinus problems

Skin
☐ Boils
☐ Bruise easily
☐ Dry skin
☐ Itching/rash
☐ Sensitive skin
☐ Sore won't heal
☐ Sweating

Genitourinary
☐ Frequent urination
☐ Blood in urine
☐ Urinary incontinence
☐ Kidney infections/stones
☐ Low libido

Gastrointestinal
☐ Belching, gas or bloating
☐ Constipation
☐ Diarrhea
☐ Difficulty swallowing
☐ Distension of abdomen
☐ Excessive hunger
☐ Gallbladder problems
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Stomach pain
☐ Poor appetite
☐ Vomiting

Reproductive
☐ Erectile dysfunction
☐ Prostate problems
☐ Bleeding between periods
☐ Painful periods
☐ Clots in menses
☐ Excessive menstrual flow
☐ Irregular cycle
☐ Menopausal symptoms
☐ PMS
☐ Previous miscarriage
☐ Scanty menstrual flow
☐ Infertility
☐ Could you be pregnant?

Pain/Weakness/Numbness
☐ Arms
☐ Hips
☐ Back
☐ Legs
☐ Shoulders
☐ Neck
☐ Hands
☐ Feet
☐ Other

Muscle/Joints/Bones
☐ Tremors
☐ Cramps
☐ Swollen joints

Signature - The information on this form is correct to the best of my knowledge.	
Patient signature:	**Date**

Pacific Coast Community Acupuncture
Financial Agreement

Pacific Coast Community Acupuncture makes every attempt to make complementary health care, in the form of acupuncture and Traditional Chinese Medicine, available to as many people as possible, at the most affordable rates. We provide high quality treatments in a supportive community setting.

We practice a style of acupuncture which mostly uses distal points in the hands, feet and head to treat problems anywhere in the body – meaning that we will probably treat pain in your back by placing tiny needles in your hands.

Research in the United States (as well as thousands of years of tradition in Asia) has shown that acupuncture is most effective when it is done frequently and regularly – once a week is usually the minimum required to make progress on any kind of health problem.

Community Fee Structure

There is a one-time $10 paperwork fee with the first appointment.

Acupuncture treatments are on a sliding scale of $15-$35 per treatment.

You decide how much you want to pay for your treatment.

The purpose of the sliding scale is to separate the issues of money and treatment. We want you to come in often enough to really get better and stay better! We understand that everyone's situation is different, and our primary goal is to make acupuncture available to you as often as you need it.

In respect for our intention to offer high quality health care at affordable prices, we ask for 24-hour notice if you need to cancel or reschedule an appointment.

All appointments that are rescheduled or cancelled with less than 24-hour notice, and appointments missed without notice, will be charged a $15 fee.

Thank you for your understanding,
Pacific Coast Community Acupuncture Staff

Printed Name	
Patient signature:	**Date**

ACUPUNCTURE INFORMEN CONSENT TO TREAT

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 the patient named below, for who I am legally responsible for) 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.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the sites that may last for a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects may occur. The herbs and nutritional supplements (which are from plant, animal, and other mineral resources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all the possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgement 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 the results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all of my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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 signature or patient representative:	**Date**
Relationship if signing for patient:	

Susan Kim, L.Ac. Dipl. OM
Craig Swogger, L.Ac. DAOM
Jenny Garcia, L.Ac.
William Janes, L.Ac.
Cassie Warren, L.Ac.

PACIFIC COAST COMMUNITY ACUPUNCTURE
ACKNOWLEDGEMENT OF RECEIPT OF PATIENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I read and/or received a copy of the Pacific Coast Community Acupuncture Notice of Privacy Practices

Patient signature	**Date**