

Intake Form

ORIENTAL MEDICAL ASSOCIATES
4002 Park Blvd. STE E
San Diego, CA 92103
(619) 294 - 2622

Thank you for taking the time to fill out this confidential questionnaire to help me determine the best treatment plan for you. If you have any questions, please ask.

Personal Information:

Date: _____

Name _____ M / F
Home Address _____
City / State / Zip _____

Home Phone _____ / _____ SSN: _____
Occupation _____ Employer _____
Employer's Address _____
Work Phone _____ Email: _____

Birthdate / Age _____ / _____ Marital Status _____ Number of Children _____

Emergency Contact _____ Phone _____
Relationship _____

Have you previously received acupuncture therapy? _____

How did you select our office? _____

Did your injury occur at work? Y / N Describe: _____

Medical Physician / Phone _____

Are you Pregnant? _____

Payment

I, the undersigned, understand that payment for all care received is my responsibility. I also understand that a 24 hour cancellation notice is necessary to avoid charges. **Payment is due at time of service.**

Insurance and Worker's Compensation

I authorize the release of any medical or other information necessary to process my insurance claim. I also request payment of government benefits either to myself or to Oriental Medical Associates should my case be accepted. I authorize payment of medical benefits to Oriental Medical Associates for services billed to my insurance carrier.

Informed Consent

I hereby request and consent to the performance of Acupuncture and other Oriental Medical procedures by the Licensed Acupuncturists at Oriental Medical Associates, or associates, or employees. I understand that infrequently, a small amount of bruising may accompany an acupuncture or associated treatment modality. I have read the above consent.

Signature: _____

Date: _____

ACUPUNCTURE QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

NAME _____ Date _____ Time _____ Account No. _____

Birth Date: _____ Height _____ Weight _____

Major Complaint/s _____

Other Complaints: _____

Date of onset (when you first noticed your problem)? _____

Pain is: Minimal Slight Moderate Severe

How long have you had this condition? _____

Have you had this in the past? Yes No When? _____

What makes it better? _____

What makes it worse? _____

Is your condition: Getting worse Constant Comes and Goes

Medications/Drugs/Herbs you are currently taking: _____

List Surgeries/Operations you have had and dates: _____

Date of your last physical examination _____ By whom? _____

The following is a list of symptoms that you may experience. Please indicate as follows:

- | | |
|--|---|
| <input type="checkbox"/> lack of appetite | <input type="checkbox"/> eye problems |
| <input type="checkbox"/> excessive appetite | <input type="checkbox"/> jaundice (yellowish eyes or skin) |
| <input type="checkbox"/> loose stool or diarrhea | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> digestion problems, indigestion | <input type="checkbox"/> difficulty digesting oily foods |
| <input type="checkbox"/> vomiting | <input type="checkbox"/> gall stones |
| <input type="checkbox"/> belching or burping | <input type="checkbox"/> light colored stool |
| <input type="checkbox"/> heartburn | <input type="checkbox"/> soft or brittle nails |
| <input type="checkbox"/> feeling of retention of food in the stomach | <input type="checkbox"/> easily angered or agitated |
| <input type="checkbox"/> tendency to become obsessive in your work, relationships... | <input type="checkbox"/> difficulty making plans or decisions |
| <input type="checkbox"/> insomnia, difficulty sleeping | <input type="checkbox"/> spasm or twitching of muscles |
| <input type="checkbox"/> heart palpitations | <input type="checkbox"/> low back pain |
| <input type="checkbox"/> cold hands and feet | <input type="checkbox"/> knee problems |
| <input type="checkbox"/> nightmares | <input type="checkbox"/> hearing impairment |
| <input type="checkbox"/> mentally restless | <input type="checkbox"/> ear ringing |
| <input type="checkbox"/> laughing for no apparent reason | <input type="checkbox"/> kidney stones |
| <input type="checkbox"/> angina pains | <input type="checkbox"/> decreased sex drive |
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> hair loss |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> urinary problems |
| <input type="checkbox"/> sciatic pain | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> headaches | <input type="checkbox"/> edema |
| <input type="checkbox"/> cough | <input type="checkbox"/> blood in stool |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> black "tarry" stool |
| <input type="checkbox"/> decrease sense of smell | <input type="checkbox"/> easily bruised |
| <input type="checkbox"/> nasal problems | <input type="checkbox"/> difficult to stop bleeding |
| <input type="checkbox"/> skin problems | <input type="checkbox"/> asthma |
| <input type="checkbox"/> feeling of claustrophobia | <input type="checkbox"/> tendency to catch colds easily |
| <input type="checkbox"/> bronchitis | <input type="checkbox"/> intolerance to weather changes |
| <input type="checkbox"/> colitis or diverticulitis | <input type="checkbox"/> allergies |
| <input type="checkbox"/> constipation | <input type="checkbox"/> hayfever |
| <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> recent use of antibiotics | <input type="checkbox"/> tendency to faint easily |
| | <input type="checkbox"/> high cholesterol levels |

FAMILY HISTORY: (Has any member of your family had any of the above)? Yes No If yes, which member and what did they have? _____

Please list any additional comments _____

PLEASE MARK YOUR AREAS OF PAIN

