Intake Form

ORIENTAL MEDCIAL 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? ______________

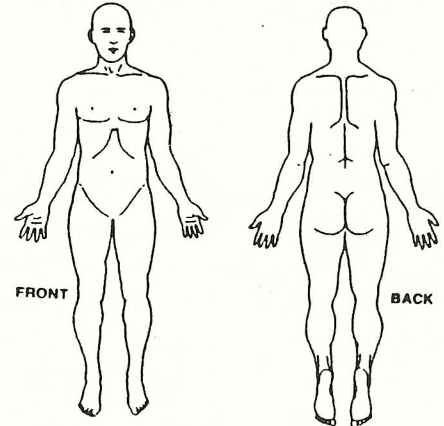
Have you had this in the past? ☐ Yes ☐ No When? ______________

What makes it better? ______________

What makes it worse? ______________

Is your condition: ☐ Getting worse ☐ Constant ☐ Comes and Goes

PLEASE MARK YOUR AREAS OF PAIN



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:

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

______________ ______________

SIGNATURE OF PATIENT

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