Biorient Integrative Clinic

PATIENT CONFIDENTIAL INFORMATION

1. Name _____ (First) _____ (Middle) _____ (Last)
2. Address _____ (Street) _____ (City) _____ (State) _____ (Zip)
3. Home Phone _____ 4. Business Phone _____
4. Cell Phone _____ 6. Email _____
5. Age _____ 8. Date of Birth _____ 9. Sex _____ 10. Marital: M S D W
6. Social Security No _____ 12. Driver's License No _____
7. Occupation _____ 14. Employer _____

Employer's Address _____ (Street) _____ (City) _____ (St .) _____ (Zip)

8. Bank _____ (Name) _____ (Address) _____ (Account No.)

CASE HISTORY

9. Chief Complaint _____
10. Complaint result of: ☐ Auto Accident ☐ Injury ☐ Job Related ☐ Other
11. Date of accident/Injury/Other ____ / ____ / ____
12. Have you seen any other doctor about this condition? _____ If yes, when? _____

Doctor's Name _____ Address _____

13. Have you had recent X-Rays? _____ If yes, when? _____ Area X-Rayed _____
14. Spouse's name _____ Cell phone _____ Occupation _____

Employer _____ Address _____ Phone _____

15. Nearest relative not living with you _____

Address _____ (Street) _____ (City) _____ (State) _____ (Zip) Phone _____

16. In case of emergency, call _____ (Name) _____ (Street) _____ (City) _____ (Phone)

FOR FEMALES: Are you pregnant? _____ IF YES, HOW LONG? _____

FOR MINORS: List both parents' names and addresses

_____

_____

FINANCIAL ARRANGEMENTS

How do you plan to handle your account? (Check one) ☐ Cash ☐ Check ☐ Master Card ☐ Visa

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.

DATED _____ PATIENT'S SIGNATURE _____

(parent's signature if patient is minor)

Biorient Integrative Clinic

Referred by _____

Patient Health History

Name: _____ **Date:** _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ **Age:** _____ **Gender:** M/F **Marital status:** S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care? _____

For what reason? _____

2. Has your case been referred to an attorney? Y N

3. Please identify the health concerns that have brought you to the Biorient Clinic in order of importance below:

Condition	**Past Treatment**
a. _____	_____
How does this condition affect you?	_____
b. _____	_____
How does this condition affect you?	_____
c. _____	
How does this condition affect you?	_____
d. _____	
How does this condition affect you?	_____

4. If applicable, please list any *foods*, *drugs*, or *medications* you are hypersensitive or allergic to (please include reaction):

_____

_____

5. Please list any *medications* (prescribed and over-the-counter), *vitamins*, and *supplements* you are <u>currently</u> taking:

_____

_____

_____

6. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

7. Do you have any infectious diseases? Y N If yes, please, identify: _____

8. Family History:	Father	Mother	Brothers	Sisters	Spouse	Children
Check those applicable:						
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

9. Height: _____ **Weight:** Currently: _____ Past Maximum: _____When? _____

10. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

X present blood pressure reading? _____/_____

11. Childhood Illness (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. Immunizations (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria BCG Hepatitis B

Others: _____

13. Hospitalizations and Surgeries:

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

14. X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

15. Emotional Status (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension Other:

16. Energy and Immunity (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

17. Head, Eye, Ear, Nose, and Throat (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

18. Respiratory System (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis

Shortness of Breath Other Respiratory Problems: _____

19. Cardiovascular System (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles Angina High/Low Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

20. Gastrointestinal (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

21. Genito-Urinary Tract (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

22. Female Reproductive/Breasts (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods

23. Menstrual/Birthing History:

1. Age of First Menses: _____ 4. Birth Control Type: _____ 7. # of Abortions: _____

2. # of Days of Menses: _____ 5. # of Pregnancies: _____ 8. # of Live Births: _____

3. Length of Cycle: _____ 6. # of Miscarriages: _____ 10. Other info: _____

24. Male Reproductive (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

25. Musculoskeletal (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): _____

26. Neurologic (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

27. Endocrine (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

28. Other (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____

_____

29. Lifestyle:

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Exercise routine: _____

c. Spiritual practice: _____

d. How many hours per night do you sleep? _____ Do you wake rested? Y N

e. Level of education completed: High School Bachelors Masters Doctorate Other

f. Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y/N Why/Why not? _____

g. Nicotine/Alcohol/Caffeine Use: _____

h. Have you experienced any major traumas? Y N Explain: _____

_____

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

j. Television habits: _____ Reading habits: _____

k. Interests and hobbies: _____

How did you hear about us? _____

Would you like to receive our email newsletter? (**E-mail address**) _____

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at the Chinese Medical Clinic. I understand that acupuncturists practicing in the state of California are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Cupping: I understand that if I receive cupping therapy which is an ancient form of acupuncture in which a local suction is created on the skin; practitioners believe this mobilizes blood flow in order to promote healing. Suction is created using heat (fire) or mechanical devices (hand or electrical pumps). I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the Chinese Medical Clinic as soon as possible*.

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

SIGN BELOW ***ONLY*** IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION

I requested and received, in substantial detail, further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment. I give my permission and consent to treatment.

X_____ ***X***_____

Patient's Signature Date **Explained by me and signed in my presence Date**