

Eastern Body Therapy

2310 Sixth Avenue San Diego, CA 92101 (619)239-7745office (619)772-4002cell

Personal Information

Name _____ Date of injury/illness _____

Address: _____ Apt. _____ City _____ State _____ Zip _____

Home phone: () _____ Work Phone: () _____ E-mail: _____

Social Security #: _____ Date of Birth: _____ Drivers License# _____

Employer/school _____ Full time _____ Part time _____ Occupation: _____

Spouse's name: _____ Work phone: () _____

Referred By _____

Have you had acupuncture before? _____yes _____no

Is your condition a result of a work injury? _____yes _____no Automobile accident _____yes _____no

Responsible Party Information

Responsible party: _____ Date of birth: _____

Relationship to patient: _____self _____spouse _____other _____ SS#: _____

Responsible party's home phone: () _____ Work phone: () _____

Address: _____ Apt. _____ City _____ State _____ Zip _____

Employer's name: _____ Phone number: () _____

Occupation: _____

If patient is a child, other parent's name: _____

Home address: _____ Apt. _____ City _____ State _____ Zip: _____

Home phone: () _____ Work phone: () _____ Occupation: _____

Patient's Insurance Information

PRIMARY insurance company name: _____

Insurance address: _____ City: _____ State: _____ Zip: _____

Name of insured: _____ Date of birth: _____

Relationship to patient: _____self _____spouse _____parent _____other _____

Insurance ID #: _____ Group #: _____

SECONDARY insurance company name: _____

Insurance address: _____ City: _____ State: _____ Zip: _____

Name of insured: _____ Date of birth: _____

Relationship to patient: _____self _____spouse _____parent _____other _____

Insurance ID #: _____ Group #: _____

Emergency Contact

Name: _____ Relationship: _____

Address: : _____ Apt. _____ City _____ State _____ Zip _____

Home phone: () _____ Work Phone: () _____

ASSIGNMENT OF BENEFITS – FINANCIAL AGREEMENT

Assignment and release: I authorize payment of benefits be made directly to the healthcare provider. I understand that I am responsible for any and all charges not paid by my insurance. I authorize the release of any information required by my insurance companies to process this claim, including medical records and dates of service.

Signed: _____ Date: _____

History of current complaint

Reason for today's visit _____

How long have you had these symptoms? _____

What other treatment have you had for this condition? _____

What seems to make it better? _____

What seems to make it worse? _____

Please list other conditions for which you are under the care of a physician: _____

What medications are you taking? (Please include over the counter medications, herbs, and vitamins as well as prescription medications) _____

Do you know what your blood pressure usually is? ____yes ____no if yes: ____/____

Lifestyle Information

Appetite ____low ____high ____moderate

Are you vegetarian? ____yes ____no

Do you have cravings for specific foods? ____yes ____no

If yes, what do you crave? _____

How many glasses of water do you drink in a typical day? _____

Regular Exercise Type _____ How often _____

Medical History

Please check any of the following conditions you currently have or have previously had:

Now	Previous	Now	Previous	Now	Previous
<input type="checkbox"/>	<input type="checkbox"/> Alcoholism	<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Pacemaker
<input type="checkbox"/>	<input type="checkbox"/> Allergies	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy	<input type="checkbox"/>	<input type="checkbox"/> Pneumonia
to what _____		<input type="checkbox"/>	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/> Polio
_____		<input type="checkbox"/>	<input type="checkbox"/> Gout	<input type="checkbox"/>	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/> Anemia	<input type="checkbox"/>	<input type="checkbox"/> Heart Disease	<input type="checkbox"/>	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/> Appendicitis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Seizures
<input type="checkbox"/>	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/> Herpes	<input type="checkbox"/>	<input type="checkbox"/> Stroke
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Thyroid Disorders
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/> Tuberculosis
type _____		<input type="checkbox"/>	<input type="checkbox"/> History of Abuse	<input type="checkbox"/>	<input type="checkbox"/> Ulcers
_____		<input type="checkbox"/>	<input type="checkbox"/> Measles	<input type="checkbox"/>	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/> Mental Illness	<input type="checkbox"/>	<input type="checkbox"/> Other (Please
<input type="checkbox"/>	<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Multiple Sclerosis	explain) _____	
<input type="checkbox"/>	<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/> Mumps	_____	

Please list dates and types of all surgeries you have had: _____

Please list any major traumas and accidents you have had: _____

Family Medical History

Please check any of the following that someone in your immediate family (sisters, brothers, parents, grandparents, aunts, uncles) has had

Condition	Who has it?	Condition	Who has it?
Allergies	_____	Diabetes	_____
Asthma	_____	Heart Disease	_____
Alcoholism	_____	High Blood Pressure	_____
Cancer	_____	Seizures	_____

General Symptoms

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Muscle cramps |
| <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Heavy sleep | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Vertigo or dizziness |
| <input type="checkbox"/> Prefer cold drinks | <input type="checkbox"/> Dream disturbed sleep | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Bleed or bruise easily |
| <input type="checkbox"/> Prefer hot drinks | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fever | <input type="checkbox"/> Peculiar taste in mouth |
| <input type="checkbox"/> Recent weight gain/loss | <input type="checkbox"/> Lack of strength | <input type="checkbox"/> Chills | |
| | <input type="checkbox"/> Bodily heaviness | <input type="checkbox"/> Night sweats | |
| | | <input type="checkbox"/> Sweat easily | |

Head, Eyes, Ears, Nose, Throat

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Excessive phlegm | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> TMJ | <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Gum problems | <input type="checkbox"/> Lumps in throat | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Excessive saliva | | _____ |
| <input type="checkbox"/> Night blindness | | | _____ |
| <input type="checkbox"/> Glaucoma | | | _____ |
| <input type="checkbox"/> Cataracts | | | |

Respiratory

- | | | | |
|---|--|------------------------------------|---|
| <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Coughing blood |
| | <input type="checkbox"/> Tight chest | <input type="checkbox"/> Wet cough | |
| | <input type="checkbox"/> Asthma | <input type="checkbox"/> Dry cough | |

Cardiovascular

- | | | | |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Phlebitis | _____ |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Rapid heart beat | <input type="checkbox"/> Irregular heart beat | _____ |
| <input type="checkbox"/> Fainting | | | |

Gastrointestinal

- | | | | |
|-----------------------------------|---|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Hiccup | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Gas | <input type="checkbox"/> Bloating | <input type="checkbox"/> Constipation |
| | | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Laxative use |

- | | | | |
|---|--|---------------------------------------|--|
| <input type="checkbox"/> Black stools | <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Itchy anus | <input type="checkbox"/> Anal fissures |
| <input type="checkbox"/> White, chalky stools | <input type="checkbox"/> Intestinal pain or cramping | <input type="checkbox"/> Burning anus | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Bloody stools | | <input type="checkbox"/> Rectal pain | _____ |
| | | <input type="checkbox"/> Hemorrhoid | _____ |

Musculoskeletal

- | | | | |
|---|--|--|-------------------------------------|
| <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Limited range of motion | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Muscle weakness | _____ |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Rib pain | | _____ |

Skin and Hair

- | | | | |
|--------------------------------------|------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Acne | <input type="checkbox"/> Change in hair/skin texture | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Fungal infections | _____ |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Itching | | _____ |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Hair loss | | _____ |
| <input type="checkbox"/> Psoriasis | | | |

Neuro/psychological

- | | | | |
|--------------------------------------|--|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Depression | <input type="checkbox"/> Abuse survivor | <input type="checkbox"/> Seeing a therapist |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Considered/attempted suicide | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Tics | <input type="checkbox"/> Irritability | | _____ |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Easily stressed | | _____ |

Genito-urinary

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Wake to urinate | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Incomplete urination | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Nocturnal emission |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Other_____ |
| | | | _____ |

Gynecology

- Age menses began_____

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Number of days in cycle_____ | <input type="checkbox"/> Light flow | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Age at menopause _____ |
| <input type="checkbox"/> Duration of flow_____ | <input type="checkbox"/> Clotted flow | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Date of last PAP _____ |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> PMS | <input type="checkbox"/> Pregnancies #_____ | <input type="checkbox"/> Date last period began _____ |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Vaginal discharge (color_____) | <input type="checkbox"/> Live births #_____ | |
| <input type="checkbox"/> Heavy flow | <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Premature births #_____ | |
| | <input type="checkbox"/> Vaginal odor | | |

Is there anything else you feel we should know about? _____

Thank you for taking the time to help us to help you!