Chung Acupuncture Clinic
6105 Snell Ave. Suite 101, San Jose, CA 95123
Tel: (408) 234-1919 Fax: (408) 578-1804

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NEW PATIENT INFORMATION

PERSONAL INFORMATION

1. Name: _____ 2. Date of Birth: _____/_____/_____
First Middle Last MM DD YYYY
3. Address: _____
Street City State Zip Code
4. Home Phone: (_____)_____ 5. Work/Cell Phone: (_____)_____
6. Email: _____
7. Age: _____ 8. Sex: ☐ F ☐ M 9. Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
10. Social Security No: _____ 11. Driver's License No: _____
12. Occupation: _____ 13. Employer: _____
14. Emergency Contact: _____(_____)_____
Name Relationship Phone
15. Height: _____ 16. Weight: _____
17. How did you hear about us? _____
18. Who do we thank for referral? _____
18. Have you received acupuncture or herbal therapy before? ☐ Acupuncture ☐ Herbs ☐ Both ☐ Neither

For Minors: Please list name(s) and address(es) of parents if different than above.
Mother: _____
Father: _____

For Payment: Please list the following information if the person responsible for payment is **NOT** the patient.
Name: _____ Relationship to Patient: _____
First Middle Last
Address: _____
Street City State Zip Code
Phone: (_____)_____ Email: _____

Insurance Information: Please list the following information if you have Medical Insurance.
Primary Insurance Co: _____
Name ID No Group No
_____
Policy Holder's Name Relationship Date of Birth
Secondary Insurance Co: _____
Name ID No Group No
_____
Policy Holder's Name Relationship Date of Birth

Office Policy: All fees for medical services are due at the time of visit unless arrangements have been made between Chung Acupuncture Clinic and your insurance company. If we are billing your insurance, you may be responsible for co-pays or unpaid balances. Please note that all published prices reflect a courtesy discount for cash patients.
Cancellation Policy: We request 24 hour notice if you need to cancel your appointment. Cancellations under 24 hours or failing an appointment are subject to a $75 charge except in the case of emergency. **Initial**: _____

Notice of Privacy Practices: I acknowledge that Chung Acupuncture Clinic has provided a written copy of its Notice of Privacy Practices for my health information. I authorize the release of any medical and other information necessary for insurance claim processing and I understand that my individually identifiable medical information will be used only as necessary for purposes of treatment, payment and other healthcare operations. **Initial**: _____

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HEALTH INFORMATION

1. Do you sleep well? ☐ Yes ☐ No What are your normal sleeping hours? _____ to _____
2. Please check the boxes that best describes your digestion: ☐ Good ☐ Indigestion ☐ Constipation ☐ Diarrhea ☐ Poor Appetite ☐ Cravings (specify) _____
3. Do you exercise? ☐ Yes ☐ No If yes, please specify activity: _____
   How many days a week? _____ How many minutes per session? _____
4. Please list any allergies, food sensitivities: _____
5. Have you experienced an unintended weight loss or gain of 10 pounds in the last three months? ☐ Yes ☐ No
6. Have you had recent X-Rays? ☐ Yes ☐ No If yes, when? _____ Area X-Rayed? _____
7. Have you had any accidents, surgeries or hospitalization? ☐ Yes ☐ No If yes, please specify:
   Event: _____ Year: _____
   Event: _____ Year: _____
8. Are you currently under the care of a medical doctor or other type of health care provider for any condition?
   ☐ Yes ☐ No If yes, for what condition? _____
   Name of doctor/provider: _____ Phone: (_____)_____
9. Please list any medications you are taking, the dosage, reason for taking and the date you started.

Medication	Dosage	Reason	Date Started

Lifestyle: Which of the following is/are part of your lifestyle?

☐ Tobacco Smoking ☐ Recreational Drugs ☐ Regular Exercise
☐ Coffee Drinking ☐ Birth Control Pills ☐ Relaxation/Meditation
☐ Alcohol Drinking ☐ Vitamins/Supplements ☐ Special Diet

For Females:

Are you currently pregnant? ☐ Yes ☐ No ☐ Maybe If yes, what week are you in pregnancy? _____
Number of pregnancies? _____ Number of births? _____ Are you nursing? ☐ Yes ☐ No
How old were you when you had your first period? _____
How many days from the start of your period until the start of your next period? _____
Date of last period? _____ How many days lasted? _____ Is your period regular? ☐ Yes ☐ No
Please check the box that best describes your period: ☐ Scant, thin, red ☐ Heavy, dark, clotted ☐ Normal red flow
Do you have menstrual pains or cramping? ☐ Before ☐ During ☐ After ☐ No

Family History: If a family member has had any of the following, please check the appropriate box and explain.

☐ Autoimmune disorders ☐ Cancer ☐ Diabetes ☐ Heart disease ☐ Hypertension
☐ Kidney disease ☐ Mental illness ☐ Seizure disorder ☐ Other: _____

Medical History: Please check all of the boxes below that are now or have been a part of your personal health history.

	Current	Past		Current	Past		Current	Past
Arthritis	☐	☐	Chronic Fatigue	☐	☐	HIV +	☐	☐
Abortion	☐	☐	Diabetes	☐	☐	Hypoglycemia	☐	☐
Allergies	☐	☐	(specify) _____			Injuries	☐	☐
(specify) _____			Digestive Disorders	☐	☐	Insomnia	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Irregular Pregnancy	☐	☐
Asthma	☐	☐	Epilepsy	☐	☐	Psychological Disorder	☐	☐
Blood Pressure-High	☐	☐	Headaches	☐	☐	Vaginal Infection	☐	☐
Blood Pressure-Low	☐	☐	Heart Disease	☐	☐	Thyroid	☐	☐
Bronchitis	☐	☐	Hepatitis	☐	☐	Other: _____	☐	☐
Cancer	☐	☐	(specify type) A___ B___ C___			_____	☐	☐
(specify) _____			Heavy Bleeding	☐	☐	_____	☐	☐

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HEALTH CONCERNS

1. Please list your major health concerns for which you are seeking treatment and describe other relevant information.

List your condition(s) in order of importance:	Date you first noticed:	Circle the number that best reflects your condition: **none • • • • • • • severe**	Check the box below that best represents how much of time you feel pain or symptoms:
1. _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%
2. _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%
3. _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%
4. _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

For each condition listed above, please mark how it happened:

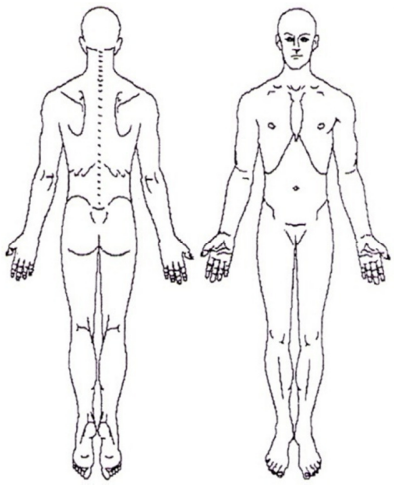
1.	☐ Developed over time	☐ Illness	☐ Injury	☐ Auto accident	☐ Other _____	☐ I don't know
2.	☐ Developed over time	☐ Illness	☐ Injury	☐ Auto accident	☐ Other _____	☐ I don't know
3.	☐ Developed over time	☐ Illness	☐ Injury	☐ Auto accident	☐ Other _____	☐ I don't know
4.	☐ Developed over time	☐ Illness	☐ Injury	☐ Auto accident	☐ Other _____	☐ I don't know

For each condition listed above, please check if it is better or worse with any of the following:

	HEAT		COLD		REST		ACTIVITY		OTHER (please specify on line below)	
	better	worse	better	worse	better	worse	better	worse	better	worse
1.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
2.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
3.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
4.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____

2. Please mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling.

+++ Sharp or stabbing
ooo Pins and needles
vvv Dull or aching
/ / / Numbness



3. Please check the box that best describes whether your pain or symptom(s) limit normal activities:

Activity	normal	somewhat limited	severely limited
Lifting	☐	☐	☐
Bending	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Sitting	☐	☐	☐
Climbing stairs	☐	☐	☐
Running	☐	☐	☐
Resting in bed	☐	☐	☐
Intercourse	☐	☐	☐
Computer work/typing	☐	☐	☐
Normal work	☐	☐	☐
Household activities	☐	☐	☐
Recreational activities	☐	☐	☐
Other (specify below)	☐	☐	☐

_____

4. Have you seen any other doctor about above condition? ☐ Yes ☐ No If yes, when? _____

Doctor's Name: _____ Phone: (_____) _____

Diagnosis: _____

Treatment: _____

Result: _____

I have read and understand the policies of Chung Acupuncture Clinic and agree to adhere to them in all respects. I certify that the above information is true and correct to the best of my knowledge and I agree to notify Chung Acupuncture Clinic immediately whenever I have changes in my health condition or health plan coverage.

Signature: _____ Today's Date: _____/_____/_____

If patient required assistance to complete, sign name and state relationship (i.e., parent, translator) below:

Name: _____ Relationship: _____ Today's Date: _____/_____/_____