

Tel: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Patient:**

\_\_\_\_\_ Last name First name MI

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex: M F: Birth date: \_\_\_\_\_ Married Single Widow Divorced Name of partner \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's license #: \_\_\_\_\_

Employed: Full Time Part Time Retired None Student: Full-time Part-time

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_ City State Zip Telephone

EMERGENCY CONTACT: Name & Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name/Address/Tel # of Primary Care Physician \_\_\_\_\_

Referred by: \_\_\_\_\_

**INSURANCE INFORMATION**

Relationship to Insured:  Self  Spouse  Child  Other/describe

Insured's Name (if different from above): \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: M F

Social Security Number: \_\_\_\_\_ Group number: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Policy/Group Number \_\_\_\_\_

**Other Insurance?** Provide Insured's name, SS#, name and address of insurance carrier, telephone number and group number: \_\_\_\_\_

Is your condition related to employment (current or past?)  Yes  No Worker's Comp?  Yes  No

Is your condition related to auto accident/personal injury?  Yes  No

If your answer to one of the above is yes, please ask receptionist for worker's comp/personal injury questionnaire.

By signing below, I hereby acknowledge that I will be responsible for any deductibles, co-pays, or services that are not covered by my insurance carrier.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## *Office Policies & Insurance*

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available for your condition. To familiarize you with our financial policies, we would like to explain how medical bills will be handled.

### ***Payment Arrangements***

Patients are responsible for fees at the time services are rendered. This includes deductibles and co-payments. Any past-due balances will be subject to a late fee. There will be a \$20.00 service charge for each returned check. We accept MasterCard, Visa, American Express and Discover card for payment.

### ***Late Cancellation/Missed Appointments***

We respect the fact that you may, on occasion, need to cancel an appointment, however, we do request a 24 hour notice. Should you cancel an appointment with less than 24 hour notice, we reserve the right to charge a late cancellation/missed appointment fee.

### ***Explanation of Insurance Coverage***

Many insurance policies cover acupuncture care, but it is your responsibility to make sure that your insurance company does. Insurance policies can differ greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another we require that you, the patient, be personally responsible for the payment of your deductible, as well as any balance unpaid by your insurance company. We will do our best to verify your insurance coverage and will bill your insurance company in a timely manner.

### ***Assignment of Benefits***

I hereby authorize payment of medical benefits by my insurance carrier, \_\_\_\_\_ directly to Janene Mitchell, L.Ac. A photocopy of this signature is as valid as the original. By signing below, you are authorizing the above.

### ***Release of Information***

If your insurance company requires medical reports to document your treatment and progress, your signature below authorizes the release of medical information necessary to process your claim.

### ***Voluntary Termination of Care***

If you suspend or terminate care at any time your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you ultimately will personally be responsible for payment.

We hope this answers any questions you might have concerning the financial policies of this office. Once again, we welcome you to our office and will be glad to answer any questions that you might have.

By signing below I hereby acknowledge that I have read the above policies and agree to the terms stated.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Janene Mitchell, L.Ac.**  
1155 S. Beverly Dr., Los Angeles, CA 90035  
Phone: 310-614-8207 \*\* Fax: 310-203-9211

Main reason for today's visit \_\_\_\_\_

Medical diagnosis, if given \_\_\_\_\_

Other symptoms \_\_\_\_\_

General concerns (things you wonder about) \_\_\_\_\_

Accidents & injuries (with dates) \_\_\_\_\_

Surgeries (dates) \_\_\_\_\_

Any allergies or drug reactions \_\_\_\_\_

Please list all medications and supplements you are taking (include the dosage if you know it):

List types of exercise you enjoy \_\_\_\_\_

How often?  None  1-2 times/wk  3-4 times/wk  5 or more times/wk

List relaxation activities \_\_\_\_\_

Which foods do you eat often? \_\_\_\_\_

Which foods do you avoid? \_\_\_\_\_

Do you eat at regular mealtimes? \_\_\_\_\_ How many meals a day? \_\_\_\_\_

How many glasses of water do you drink a day? \_\_\_\_\_ How many hours do you sleep? \_\_\_\_\_

What is your caffeine intake? (coffee, tea, sodas) \_\_\_\_\_ /day or \_\_\_\_\_ /week

How many alcoholic beverages do you have on average? \_\_\_\_\_ /day or \_\_\_\_\_ /week

Do you smoke?  Yes  No  Not any more How long have you smoked? \_\_\_\_\_ yrs

**Check if you have any of the following:**

- Cardiac pacemaker       Seizure disorder       Tendency to faint
- Bleeding disorder       Hypoglycemia       Believe you are or may be pregnant

**Family history of illness** (please give relationship: **your mother, brother, etc.**):

- High or Low Blood Pressure \_\_\_\_\_
- Heart Disease \_\_\_\_\_       Strokes \_\_\_\_\_
- High cholesterol \_\_\_\_\_       Diabetes \_\_\_\_\_
- Thyroid conditions \_\_\_\_\_       Asthma \_\_\_\_\_
- Cancers \_\_\_\_\_       Other \_\_\_\_\_

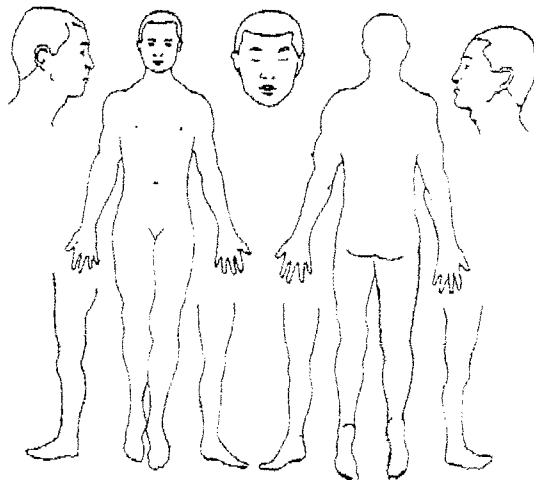
Check if you are interested in learning more about:

- Nutritional supplements       Herbal Medicine       Nutrition & Diet
- Chi Nei Tsang massage       Exercise       Qi Gong practices

**Check box for symptoms:**

- Chills      Fever
- Cough      Sore throat
- Wheezing
- Sinus congestion
- Post-nasal drip
- Loss of smell
- Headaches
- Often catch colds & flus
- Shortness of breath
  
- Dizziness
- Chest pain or pressure
- Heart palpitations
- Sweat easily
- Cold hands and/or feet
- Swollen ankles
  
- Rash \_\_\_\_\_
- Bruise easily
- Hives \_\_\_\_\_
- Dry skin      Oily skin
- Hair loss
- Ringing in ears     High     Low
- Hearing loss     R     L
- Eyes red      Dry eyes
- Floaters      Blurry vision
- Wear contact lenses

1. Place an **X** on painful areas and **###** for pins & needles:



- Dental problems      TMJ
- Sore or bleeding gums
- Neck pain      Back pain
- Other pain \_\_\_\_\_
  
- Joint pain      Swollen joints
- Muscle cramps \_\_\_\_\_
- Weakness in arms      legs
  
- Dry mouth
- Bitter taste in mouth
- Nausea      Vomiting
- Heartburn      Weight gain
- Increased appetite
- Food cravings \_\_\_\_\_
- Loss of appetite
- Gas or abdominal bloating
- Abdominal pain
- Constipation      Diarrhea
- Painful bowel movements
- Blood or mucus in stool
  
- Frequent urination
- Waking to urinate
- Difficult or painful urination
- Weak urine stream
- Incontinence
- Decreased sex drive
- Testicular pain

2. **Circle** any numb areas:

- Hard to concentrate
- Poor memory
- Insomnia      Waking early
- Restless sleep
- Night sweats
- Feel hot or cold easily
- Fatigue
- Depression      Sadness
- Irritability      Anger
- Anxiety      Nervousness

**Your History of Illnesses with Age of onset:**

- Mumps
- Measles
- Chicken pox
- Pneumonia
- Tuberculosis
- Rheumatic fever
- Scarlet fever
- Mononucleosis
- Herpes
- Epstein-Barr virus
- Hepatitis B or C
- HIV/AIDS
- Asthma
- Allergies
- Migraines
- Sinus infections
- Arthritis
- Hypothyroidism
- Hyperthyroidism
- Diabetes
- Heart disease
- Stroke
- Anemia
- High/Low Blood Pressure
- High cholesterol
- Gall bladder disease
- Ulcers
- Colitis or Crohn's Disease
- Irritable Bowel Syndrome
- Kidney disease
- Urinary infections
- Kidney stones
- Prostate problems
- Infertility
- Auto-immune disease

Other \_\_\_\_\_

## Gynecological History

When did you first begin to menstruate? age \_\_\_\_\_

Is your menstrual cycle regular?  Yes  No

How long is it usually ? \_\_\_\_\_ days (count from Day 1 to beginning of next period)

How many days does your menstrual flow last? \_\_\_\_\_

The amount is:  light  moderate  heavy

Color:  pale pink  red  bright red  dark red  purplish  brownish

Clots:  small clots  large clots  no clots

Cramps:  none  mild  moderate  severe

When:  before period  Day 1  Day 2  after period

Where:  lower abdomen  low back  rectovaginal  down thighs

Do your cramps feel better with heat?  Yes  No

Do you have bleeding at other times of the month?  No  Yes at \_\_\_\_\_

Check any of the following you notice at **ovulation** (about mid-cycle):  pelvic twinges

increased vaginal discharge  stronger sex drive  pelvic pain

Check any symptoms you have noticed during the month:

- |  |                                       |  |  |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> fatigue       | <input type="checkbox"/> constipation | <input type="checkbox"/> feeling bloated   | <input type="checkbox"/> breast tenderness   |
| <input type="checkbox"/> food cravings | <input type="checkbox"/> diarrhea     | <input type="checkbox"/> irritability      | <input type="checkbox"/> breast lumps        |
| <input type="checkbox"/> dizziness     | <input type="checkbox"/> mood swings  | <input type="checkbox"/> nervousness       | <input type="checkbox"/> forgetfulness       |
| <input type="checkbox"/> headaches     | <input type="checkbox"/> depression   | <input type="checkbox"/> vaginal discharge | <input type="checkbox"/> difficulty sleeping |
| <input type="checkbox"/> hot flashes   | <input type="checkbox"/> palpitations | <input type="checkbox"/> warmer at night   | <input type="checkbox"/> painful intercourse |
| <input type="checkbox"/> night sweats  | <input type="checkbox"/> anxiety      | <input type="checkbox"/> sore low back     | <input type="checkbox"/> vaginal dryness     |

Have you stopped menstruating?  Yes  No Date of last period \_\_\_\_\_

Have you ever been diagnosed with any of the following:

- endometriosis  uterine fibroids  breast tumors  fibrocystic breasts  
 ovarian cysts  poly-cystic ovarian syndrome  cervical or uterine cancer

Do you have any children?  Yes  No Ages \_\_\_\_\_

Any difficulties during labor? \_\_\_\_\_

Number of pregnancies \_\_\_\_\_ Pre-term pregnancies \_\_\_\_\_

Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_

Check the types of contraception you have used:  Birth control pills  IUD

Depo-Provera  Condoms  Diaphragm  Rhythm method

Do you have any questions? \_\_\_\_\_

---