Pacific Beach Acupuncture
Dr. Santana, DACM, L.Ac.

Name:_____ Date: _____

Address:_____

Phone: _____Email address:_____

Emergency Contact & Number: _____

Date of Birth: _____/_____/_____ Age:_____ Marital Status: S M living with W

Have you had acupuncture before? _____

Who may I thank for referring you here? _____

What are the top 4 health concerns that brought you to PB Acu today?

Condition **How long have you had it?**

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? _____

Please list any foods, medications or environmental substances you are hypersensitive / allergic to and their reactions:

_____

_____

Please list any medications (prescribed or over the counter), vitamins, herbs or supplements you are currently taking:

_____

_____

_____

Do you have any reason to believe you might be pregnant? Y N

If so, how far along are you? _____
Do you have children? _____ How many? _____

Do you have any infectious diseases? Y N If yes, which ones: _____

Blood Pressure: What is your most recent reading: _____/_____ When was this reading? _____

Childhood Illnesses (please circle any you may have had): Scarlet Fever Rheumatic Fever
Diphtheria Mumps Measles Chickenpox German measles Polio

Other : _____

Hospitalizations and Surgeries :

Reason	When	Reason	When
_____		_____	
_____		_____	

In this section please *circle* any symptoms/conditions you experience now and *underline* any you have experienced in the past:

Emotional :

Mood Swings Nervousness Mental Tension Depression Anxiety Stress

Energy and Immunity :

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

Head, Eye, Ear, Nose and Throat:

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts

Tearing/Dryness Impaired Hearing Ear Ringing Headaches Sinus Problems

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

Respiratory:

Pneumonia Frequent Colds Difficulty Breathing Persistent Cough

Shortness of Breath Asthma Allergies

Other Respiratory Problems_____

Cardiovascular :

Heart Disease Chest pain Swelling of Hands or Feet High Blood Pressure

Palpitations/ Flutter Stroke Heart Murmurs Varicose Veins Rheumatic Fever

Other Cardiovascular Problems: _____

Gastrointestinal:

Ulcers Changes in Appetite Nausea/Vomiting Stomach Pain Excess Gas

Heartburn Gallbladder Disease Liver Disease Hepatitis Hemorrhoids

Abdominal Pain Bloating Constipation Diarrhea Rectal Bleeding

IBS Diverticulitis

Genito-Urinary:

Kidney Stones Kidney Disease Painful Urination Frequent Urination

Blood in Urine Frequent Urinary Infections Frequent Urination at Night

Menstrual/ Birthing History:

Irregular Cycle Breast Lumps/Tenderness Heavy Periods Vaginal Discharge

Menopausal Symptoms Premenstrual Problems Bleeding between Cycles Clotting

Painful Periods Infertility When was last Pap Smear? _____ Results:_____

Female Reproductive:

Age of First Menses?_____ # Days of Menses: _____

Length of Cycle: _____ Birth Control Type: _____ # of Pregnancies: _____

# of Miscarriages: _____ # of Live Births: _____ # of Abortions: _____

Male Reproductive:

Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge

Musculoskeletal:

Neck/ Shoulder Pain Upper Extremity Pain Lower Extremity Pain Muscle Weakness

Back Pain: Upper Mid Lower Joint Pain : Where: _____

Neurologic :

Vertigo/Dizziness Paralysis Numbness/ Tingling Loss of Balance Seizures

Endocrine:

Hypothyroid Hyperthyroid Hypoglycemia Diabetes Night Sweats

Feeling Hot/Cold

Other:

Anemia Cancer Eczema/Hives Cold Hands/ Feet

Is there anything else we should know? _____

Lifestyle:

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

Are you on a particular diet or avoiding any group of foods? _____

_____

Do you exercise? Y N If yes, how long/ how many days per week? _____ /_____

How many hours per night do you sleep? _____ Do you wake up during the night? Y N

Do you go back to sleep w/o problem? Y N Do you wake up rested? Y N

Occupation _____ How many hours per week do you work? _____

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

Nicotine/Alcohol/Caffeine Use: _____

Addictions or drug use: _____

Have you experienced any major trauma? Y N Explain: _____

_____

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

Interests/ Hobbies _____

Please Note that Pacific Beach Acupuncture has a 24h appointment cancellation notice. Any patient that cancels with less than 24h hours to the appointment time will be subject to a $30 fee, up to Dr. Santana's discretion.

I, _____ acknowledge the 24h cancellation policy and I am aware of the cancellation fee.

Signature: _____ Date: _____

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other ChineseMedicine procedures, including various modes of physio-therapy on me (or on patient named below, for whom I am legally responsible) by the below named licensed acupuncturist

I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), gua sha, Chinese or Western herbs, and nutritional counseling.

I have had the opportunity to discuss with the acupuncturist named below the nature and purpose or acupuncture treatments and other procedures. Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infections and scarring. There have been extremely rare instances reported of pneumothorax.

There may be some bruising after cupping or gua sha.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine.

I understand that some herbs may be inappropriate during pregnancy

. If I experience any gastro-intestinal upset or allergic reactions to the herbs I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above consent.

I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-name procedures. I intend

this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's name and/or guardian: _____

Patient's signature:_____

Date: _____/_____/_____

Licensed Acupuncturist: Valeria Santana, L.Ac. #AC18344

Insurance Coverage important items:

I'm very happy that now most of us can receive Acupuncture and have our insurance pay for it. However, it's rarely as easy as it sounds. Please read through this entire page and make sure your insurance will reimburse your treatment. Although my billing agency has this information correct most of the times, it's still your responsibility to keep your information updated and to inform me of any changes to your policy and/or coverage.

Please note that you are responsible for any unpaid balance that the insurance did not cover.

Please answer these following questions and initial next to each statement at bottom of page.

Do you need a referral from a primary care doctor? Yes / No

Is there a dollar limit per year? Yes / No

If yes, what is the dollar limit? $_____

Is there a limit to the number of visits allowed per year? Yes / No

If yes, how many are allowed per year? _____

Does your insurance company cover the conditions you wish to be treat? Yes / No

* Some insurance plans come with deductibles. A deductible is an up-front amount that the patient must pay out of their pocket before their insurance company will cover treatments. Deductibles can range from $200-$2000. You are responsible for the entire cost of treatment until you have met the deductible. _____

* You must always pay your co-pay and/or co-insurance. _____

* Acupuncture treatments may include manual therapy in form of Tui Na, Cupping and/or Gua sha, which are billed under the Physical Therapy code of 97140. Please note: for some insurance policies, billing this code counts towards the number of allowed PT treatments available. If you do not wish to have any type of manual therapy, please advise Dr. Santana at time of treatment. _____

* Most health insurance only covers certain conditions. Different plans have different policies. Some cover for pain management, some only cover chronic pain, some only cover morning sickness. Be sure to check with your insurance company to find out the conditions of your own insurance coverage. Fertility treatments are, unfortunately, not covered. _____

* If you have recently switched to a new insurance company, please make sure that your new insurance does not have a three to six month waiting period. Some plans will not cover treatments for pre-existing conditions during the waiting period. You are responsible for informing PB ACU CLINIC of any changes and you are responsible for any unpaid amounts. _____

* Assignment of Benefits

I hereby authorize payment of medical benefits by insurance carrier, directly to PB ACU CLINIC and/or Dr. Santana. A photocopy of this signature is as valid as the original. _____

* 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. _____

_____ Date: _____

Signature of patient or parent