California Neurohealth patient information

Patient Name_____

Address_____city_____

Zip_____ Home phone (___) ___-____ Work phone (___) ___-____

Cell phone (___) ___-____ Fax (___) ___-____

Email Address _____

Date of Birth __-__-____Age _____ social security number___-__-____

Emergency Contact _____Phone (___) ___-____

Referred by _____

Employment Status:

Full time ○ Part time ○ Retired ○ Unemployed ○ student ○

Occupation_____

Employer's Name_____

Phone (___) ___-____ Employer's Address_____

Primary healthcare source:

Physician name_____Phone_____

Physician's Address_____

Date of last exam __-__-____

Chief complaint of last

exam_____

Have you ever had Acupuncture or Chiropractic Treatment? When, by Whom and for what reason?

_____

_____

Are you presently being treated for a medical Condition by a Medical Doctor? Please describe.

_____

_____

_____

Please briefly describe any chronic illness.

_____

_____

_____

What health issue(s) do you want treated? Please describe as fully as possible._____

_____

_____

_____

_____

_____

_____

What other treatments have been using for relief of this issue?

_____

_____

_____

Do you have other health concerns?

_____

_____

_____

On a scale of 0-10, 10 being someone who will do whatever it takes to get their health back and 0 being not willing to do anything , where are you on this scale?

_____

Medical Insurance Status: Self_○ Private Insurance_○ Medi-care_○ Workmen's Comp_○ Other _____

Please be respectful of our time. Your commitment begins at the moment you make an appointment. There are times when a cancellation is necessary; however please give advanced notice whenever possible. Missed or cancelled appointments with out a twenty four (24) hour notice will be charged in full. If no cancellation arrangements are made, the cost of the appointment will be charged.

Patient signature_____Date_____

"California Neurohealth informed consent"

I consent to acupuncture, Chiropractic adjustments and other procedures associated with California Neurohealth's Medical staff, (that is Licensed Acupuncturist, Chiropractic Neurologist, Guest Acupuncturist, Licensed Massage Therapist, Licensed Aesthetician, and other members of clinic's medical staff). I have discussed the nature and purpose of my treatment with the clinical staff and understand that methods of treatment may include, but not limited to acupuncture, moxibustion, cupping, electrical stimulation, massage, Chinese herbal medicine, chiropractic manipulation, therapeutic and brain based exercise, nutritional counseling and lab testing.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects. Bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur. I have been informed that chiropractic is a safe method of treatment, but that it may have side effects. Pain, bruising, increased soreness, transient tingling and numbness and fractures in patients with low bone density have all been reported and all of these risks are greatly reduced with appropriate history taking, examination and proper application of technique. Extremely rare cases of stroke temporally associated with upper neck manipulation have also been reported in medical literature but the most current and valid research shows that you are no more likely to have a stroke with chiropractic upper neck manipulation than you are with visiting your medical doctor and not receiving manipulation. Furthermore patients who receive chiropractic care have a lower risk of stroke than those who do not.

_____

Signature of patient or parent/guardian

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, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. **Herbal formulas and acupuncture points may have effects on pregnancy. Patients <u>Must</u> inform the practitioner of any possibility of pregnancy. I will notify my practitioner if I am or become pregnant.**

I understand that the herbs may need to be prepared and the tea consumed according to the instructions provided orally and /or in writing. The herbs may have an unpleasant smell and/or taste. I will immediately notify my practitioner of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinic medical staff to exercise judgment during the course of treatment which the clinic medical staff thinks at the time, based upon the facts then known, is in my best interests.

I understand the clinical medical 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.

By voluntary signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

	_____
	Name of practitioner
_____	_____
Print name of patient	**Name of practitioner**
_____	_____
Signature of patient or parent/guardian	**Signature of practitioner**
_____	_____
Print name of parent/guardian of Minor	**Signature of practitioner**
_____	_____
Date of Consent Completed	**Signature of witness/ Translator**

I have read and understand HIPAA_____

California Neurohealth Patient Insurance Information

Patient Name: _____ Gender: M ◯ F ◯
Street Address: _____

_____

Home Phone: _____ Marital Status: M ◯ S ◯ D ◯ W ◯
Social Security#: _____ Date of Birth: _____
Insured's Name: _____
Insured's ID/Claim#: _____ Group#: _____
Insurance Company: _____
Claims Address: _____
Insurance Company Phone Number (for Providers): _____

Type of Case (circle one): Health Insurance ◯ Workers Comp ◯ Personal Injury ◯
Date of Injury/Accident: _____
Attorney Name (if applicable): _____
Attorney Address: _____
DIAGNOSIS: _____ _____ _____ _____ Assign Date: _____

_____

Patient Name _____ DOB _____
Parents or Guardian _____

_____

We ask that payment of services are made at the time of treatment. If your insurance covers acupuncture and/or chiropractic, we will bill them for you. Fees for treatment do not include the cost of herbs or supplements. Having insurance is not a substitute for payment. Many companies have fixed allowances or reimburse based on a percentage that is pre-determined on your contract with them. It is the patient's responsibility to pay the deductible, co-payment, and any other balances not paid by your insurance.

Assignment and Release:

I hereby assign my insurance benefits to be paid directly to the provider of service. I understand that I am financially responsible for any non-covered services. I also authorize the provider to release any information required to process any claims.

Signature of patient _____ Date _____

Family History and Review of Systems

Family History: please place a check in the appropriate place

	Self	Mother	Father	Sister	Brother	Child	Spouse
Allergies	☐	☐	☐	☐	☐	☐	☐
Blood Disorder	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Tumors	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Kidney or Bladder disorder	☐	☐	☐	☐	☐	☐	☐
Stomach or intestinal disorder	☐	☐	☐	☐	☐	☐	☐
Drug abuse	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Depression or Mental illness	☐	☐	☐	☐	☐	☐	☐
Hormonal or Thyroid problems	☐	☐	☐	☐	☐	☐	☐
Neurological disorders	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐
Chills	☐	☐	☐	☐	☐	☐	☐
fever	☐	☐	☐	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐	☐	☐	☐
Excess thirst	☐	☐	☐	☐	☐	☐	☐
weight loss	☐	☐	☐	☐	☐	☐	☐
weight gain	☐	☐	☐	☐	☐	☐	☐
Aversion to heat	☐	☐	☐	☐	☐	☐	☐
Aversion to cold	☐	☐	☐	☐	☐	☐	☐
Low Back Pain	☐	☐	☐	☐	☐	☐	☐
Joint disorder	☐	☐	☐	☐	☐	☐	☐
Moderate Stress level	☐	☐	☐	☐	☐	☐	☐
High Stress level	☐	☐	☐	☐	☐	☐	☐
Low Stress Level	☐	☐	☐	☐	☐	☐	☐

Please check the ones that apply:

Sleep Problems:

☐Trouble falling asleep, ☐Trouble staying asleep,
☐Trouble staying awake, ☐Light sleep, ☐wake-up tired,
☐Early Morning waking , ☐Wake-up many times, ☐Lots of Dreams
How many hours do you sleep each night?

_____

Sweating:

☐Rarely sweat, ☐Night sweats, ☐Excess sweating , ☐Spontaneous sweating

Please check the ones that apply:

Skin: ☐Dry, ☐Itchy, ☐Moist, ☐Burning, ☐Blood not clotting , ☐Hives, ☐Boils,
☐Bruise easily , ☐Genital warts, ☐Herpes: oral/ genital, Other body Areas
☐Hair loss/thinning, ☐Changing Mole, ☐Frequent Rashes, ☐sores
☐Acne, ☐Puffy, ☐Wrinkles, ☐Dark Circles around eyes, Other:_____

Neurological: ☐Pain, ☐Tremors, ☐Seizures, ☐numbness, ☐Tingling , ☐Twitching
☐Muscle Cramping, ☐Muscle Weakness, ☐Muscle Atrophy,
☐Dizziness,
☐Paralysis
Location:_____
_____
☐Have you ever had a Stroke? date(s)?

_____

Post stroke problems:

_____

Head and Neck: ☐Concussion, ☐Head Aches, ☐Migraine Head Ache,
☐Tension Head Ache, ☐Menstrual Migraine, ☐Sinus Head Ache,
☐Head Ache due to Neck Injury
Location of
pain_____
☐Memory Loss, ☐Blurred Vision, ☐Eye Pain, ☐Neck Pain ,
☐Neck Stiffness.

Genito-Urinary: ☐Frequent Urination, ☐Painful or Burning upon Urination.
☐Difficult Urination, ☐Blood in Urine,

☐Frequent Infections, ☐stones, ☐unable to hold urine,
☐Other_____

Ear, Nose and Throat: ☐Ear Aches, ☐Ear discharge, ☐Frequent Ear Infections
☐Ringing in the Ear, ☐Poor Hearing
☐Sinus problems, ☐Frequent Sinus Infections, ☐Allergies
☐Frequent Colds Other_____

Chest: ☐Trouble Breathing , ☐Trouble Breathing at night,
☐ Shortness of breath
☐Pain/Pressure in the Chest , ☐Palpitations
☐Mucous rattle when Breathing
☐Wheezing, ☐Persistent Cough, ☐Chest Pain,
☐Coughing Blood
☐Coughing Phlegm, What color Phlegm?
☐Have had a Heart Attack (s), Date(s):_____
☐Have had Heart Surgery? _____
Date (s):_____Other:_____
_____

Emotional: ☐Anxiousness, ☐Depression, ☐Easily Angered, ☐Irritable ,
☐Frequent Crying, ☐Moody, ☐Mind not Clear, ☐Manic,
☐Obsessive ☐Compulsive, ☐Fearful, ☐Difficulty Expressing Emotions,
☐Other: _____

Screening: Have you ever had infection screenings for:
☐HIV, ☐TB, ☐Hepatitis, ☐Gonorrhea, ☐Chlamydia, ☐Syphilis,
☐Genital warts, ☐Herpes: oral/ genital, Other body Areas
Which one(s) did you test positive for, if any ?

Surgeries, hospitalizations, major infections, traumas, accidents, injuries (please list-with dates):

_____
_____
_____
_____

Please check the ones that apply:

Gastro-Intestinal:

	Often	Seldom	Severe	Mild	None
Constipation	☐	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐	☐
Poor Appetite	☐	☐	☐	☐	☐
Excessive Appetite	☐	☐	☐	☐	☐
Nausea	☐	☐	☐	☐	☐
Vomiting	☐	☐	☐	☐	☐
Belching	☐	☐	☐	☐	☐
indigestion	☐	☐	☐	☐	☐
Stomach Pain	☐	☐	☐	☐	☐
Lower-abdominal pain	☐	☐	☐	☐	☐
Bloody Stool	☐	☐	☐	☐	☐
Black Stool	☐	☐	☐	☐	☐
Mucus in Stool	☐	☐	☐	☐	☐
Stools have Foul Odor	☐	☐	☐	☐	☐
Hemorrhoids	☐	☐	☐	☐	☐
Lower Bowel Gas	☐	☐	☐	☐	☐
Colon Problems	☐	☐	☐	☐	☐
Anal Fissures	☐	☐	☐	☐	☐
Intestinal Bloating	☐	☐	☐	☐	☐

Life Style Habits: Please indicate how much, how many, how often:

Do you drink Coffee: ☐Yes ☐No How many cups per day/week? _____

Do you use Marijuana: ☐Yes ☐No How many times per day/ week? _____

Do you smoke Cigarettes or Nicotine ☐Yes ☐No How many times per day/per week? _____

Do you drink Alcohol? ☐Yes ☐No, (type)_____amount per day/ per week _____

Recreational Drugs: ☐Yes ☐No, Which one(s) How many times per day/ week? _____

_____

Do you use Prescription pain Medications: ◯Yes ◯No

How many times per day/ week?

Please explain which kind of pain medications you are using:

_____

_____

Please take a moment and write down all the medications that you are currently taking. This page is important in prevention of herbal drug interactions.

Prescription Drugs, Please check the ones that apply:

__Blood thinning Pills, __Blood Pressure Pills, __Tranquilizers, __Antacids, __Oral Contraceptives, __Insulin, __Diabetic Pills, __Antidepressants,__Anti-Anxiety,__Steroids,__Other

Please write down Medication Names:

1._____ used for the _____ Problem

2._____ used for the _____ Problem

3._____ used for the _____ Problem

4._____ used for the _____ Problem

5._____ used for the _____ Problem

6._____ used for the _____ Problem

Over the Counter Drugs:

__Aspirin , __Antacid, __Ibuprofen, __Laxatives, __Diet Pills;__Sleeping Pills, __Acetaminophen (Tylenol), __Allergy Pills, __Cold Medicine,

Other:_____

_____

_____

Vitamins/Supplements/

Herbs:_____

_____

Do you have any drug Allergies?_____

_____

_____

Do you have any food Allergies?_____

_____

_____

Do you have a Latex, corn or wheat Allergy? __Latex__Corn__Wheat

Exercise (Type and Frequency):

_____

Briefly describe your Diet:

_____

_____

_____

_____

_____

_____

Food Cravings:

_____

_____

--Men Only: Have you ever taken anabolic steroids?__
How long did you use them?_____
Sperm Count (if you Know):_____
Do you ejaculate on a regular basis? _____How often?
_____
How long does it take you to recover from post ejaculatory tiredness? __A few hours, __A day or two?, __All week.
How potent is your ejaculation? ____I don't feel much, ____It doesn't last long, ___It is ok,
___ejaculation is satisfying but not necessary,
___ejaculation is potent and necessary.