

# MEDIHAND ACUPUNCTURE CLINIC INC.

## PATIENT INFORMATION

Date \_\_\_\_\_ Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Sex M / F  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_  
Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Occupation \_\_\_\_\_  
Social Security Number (REQUIRED IF YOU HAVE INSURANCE) \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

## IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## INSURANCE

Person responsible for this Account \_\_\_\_\_ Insurance Co. \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Subscriber's D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## PATIENT CONDITION

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

How bad is your pain? (Circle a number) 0 1 2 3 4 5 6 7 8 9 10  
(No pain) (unbearable)

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting  
Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? Constantly Frequently Intermittently Occasionally

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down

What treatment have you had for this condition in the past? (Surgery, Medications, Injections, Therapy, Chiropractic)

Have you had X-rays, MRI or other tests for this condition? \_\_\_\_\_

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Please list any health condition or disease that you currently have: \_\_\_\_\_

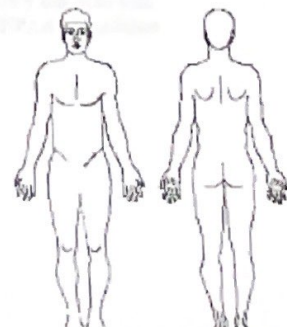
Are you ALLERGIC to any MEDICATIONS and FOOD? (Please list) \_\_\_\_\_

Are you positive for HIV/AIDS or Hepatitis virus? ☐ Yes ☐ No

**I certify that the above information is complete and accurate to the best of my knowledge.  
I agree to notify this doctor immediately whenever I have changes in my health condition  
in the future.**

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

( continued )



American Specialty Health (ASH)  
P.O. Box 509001, San Diego, CA 92150-9001  
Fax: 877.248.2746

## INITIAL HEALTH STATUS

Acupuncture and Oriental Medicine  
For questions, please call ASH at 800.972.4226

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Primary Language \_\_\_\_\_ Gender M / F  
Last First  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Primary Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Other Phone \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Primary Health Plan \_\_\_\_\_ Patient/Member ID # \_\_\_\_\_  
2<sup>nd</sup> Health Plan \_\_\_\_\_ Primary Care Physician (PCP) \_\_\_\_\_ PCP Phone # \_\_\_\_\_  
(Required) (Required)

Are you under the care of a physician? ☐ No ☐ Yes, for what conditions? \_\_\_\_\_

Please describe your current health problem(s) \_\_\_\_\_

How and When it began \_\_\_\_\_

Is this related to a specific work injury? ☐ No ☐ Yes

What treatment have you received for the above condition(s)? ☐ Surgery ☐ Medications ☐ Physical Therapy

☐ Injections ☐ Chiropractic ☐ Therapeutic Massage ☐ Other \_\_\_\_\_

Please describe your progress: ☐ Worse ☐ No Change ☐ 0-25% Better ☐ 26-50% Better

☐ 51-75% Better ☐ 76%-100% Better

Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other \_\_\_\_\_

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

In the past week, how much has your pain interfered with your daily activities?

No Interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

How often are your symptoms present? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Describe your current health overall: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

What are your goals for your acupuncture treatments? \_\_\_\_\_

How will you track your progress towards your goals? \_\_\_\_\_

### Please check all of the following that apply to you and list any medication(s) you are taking:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Alcohol/Drug Dependence                          | <input type="checkbox"/> Frequent Urination  | <input type="checkbox"/> Weight Gain/Loss         |
| <input type="checkbox"/> Abnormal Menstruation                            | <input type="checkbox"/> Headache  | <input type="checkbox"/> Sinusitis                |
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Heart Attack (date _____)   | <input type="checkbox"/> Stroke (date _____)      |
| <input type="checkbox"/> Angina   | <input type="checkbox"/> Heartburn or Indigestion  | <input type="checkbox"/> Tobacco Use - Type _____ |
| <input type="checkbox"/> Arthritis/<br>Rheumatoid Arthritis               | <input type="checkbox"/> High Blood Pressure   | Frequency _____/Day                               |
| <input type="checkbox"/> Artificial Joints (list date and<br>joint) _____ | <input type="checkbox"/> Hospitalizations<br>(date and reason) _____   | <input type="checkbox"/> Thyroid Disease          |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Surgeries (list date and type) _____  | <input type="checkbox"/> Other _____              |
| <input type="checkbox"/> Blood Disorder                                   |  |   |
| <input type="checkbox"/> Breast Lumps                                     | <input type="checkbox"/> Kidney Disease  |   |
| <input type="checkbox"/> Cancer/Tumor (type and<br>date) _____            | <input type="checkbox"/> Liver Problems  |   |
| <input type="checkbox"/> Convulsions/Seizures                             | <input type="checkbox"/> Osteoporosis  |   |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Pacemaker   |   |
| <input type="checkbox"/> Diarrhea/Constipation                            | <input type="checkbox"/> Palpitation/Arrhythmia  |   |
| <input type="checkbox"/> Excessive Thirst                                 | <input type="checkbox"/> Peptic Ulcer  |   |
| <input type="checkbox"/> Fainting or Dizziness                            | <input type="checkbox"/> Pregnant, # Weeks _____   |   |
| <input type="checkbox"/> Fatigue  | If pregnant, are you under a<br>medical doctor's care? <input type="checkbox"/> Y <input type="checkbox"/> N |   |
| <input type="checkbox"/> Fever  | <input type="checkbox"/> Prostate Problems   |   |

If a family member has had any of the following, please mark the appropriate box and explain the relationship:

- ☐ Cancer \_\_\_\_\_  
☐ Heart Disease \_\_\_\_\_  
☐ Hypertension \_\_\_\_\_  
☐ Lupus \_\_\_\_\_  
☐ Other \_\_\_\_\_

Comments \_\_\_\_\_

I certify that the above information is complete and accurate to the best of my knowledge. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services. I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage. I understand that my practitioner of acupuncture services may need to contact my Primary Care Physician or treating physician if my condition needs to be co-managed. Therefore, I give authorization to my practitioner of acupuncture services to contact my medical doctor if necessary.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_