

Welcome



Silverlake Acupuncture, Inc.
2114 Hyperion Ave
Los Angeles, CA 90027

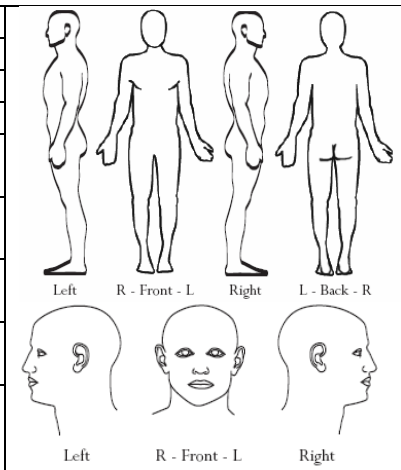
PATIENT INFORMATION	
Patient Name	
Address:	
City: State: Zip	
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Age: Birth Date:	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> DP <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
Patient SS#:	
E-Mail Address:	
Occupation:	
Employer:	
Employer Address:	
Employer Phone:	
Spouse's Name:	
Spouse's Birth Date: SSN:	
Spouse's Occupation:	
Spouse's Employer:	
Who may we thank for referring you?	

INSURANCE	
Who is responsible for this account?	
Relationship to Patient:	
Insurance Co.	
Group #	
Is Patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Subscriber's Name:	
Subscriber Birth Date: SS#:	
Subscriber Relationship to Patient	
Insurance Co.	
Group #	
ACCIDENT INFORMATION	
Is condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of accident: <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other	
To whom have you made a report of your accident?	
<input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Workers Comp	
<input type="checkbox"/> Other:	
Attorney Name (if applicable):	
Attorney Phone: Fax:	

PHONE NUMBERS	
Home:	
Work: Ext:	
Cell:	
Best time and place to reach you:	

EMERGENCY INFORMATION	
IN CASE OF EMERGENCY, CONTACT:	
Name:	
Relationship:	
Home Phone:	
Work Phone: Ext.:	
Cell Phone:	

PATIENT CONDITION			
Your Reason for this Visit:			
When did your symptoms appear?			
Is this condition getting progressively worse? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Mark an X on the picture where you continue to have pain, numbness, or tingling:			
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain):			
Type of pain: <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Throbbing <input type="checkbox"/> Numbness <input type="checkbox"/> Aching <input type="checkbox"/> Shooting <input type="checkbox"/> Burning <input type="checkbox"/> Tingling <input type="checkbox"/> Cramps <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Other:			
How often do you have the symptoms? _____ times per <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/> Constantly <input type="checkbox"/> Frequently <input type="checkbox"/> intermittently <input type="checkbox"/> occasionally			
Does it interfere with your <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily Routine <input type="checkbox"/> Recreation <input type="checkbox"/> Other			
Activities or movements that are painful to perform: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Bending <input type="checkbox"/> Lying Down <input type="checkbox"/> Other:			
What treatment have you already tried for this condition? <input type="checkbox"/> None <input type="checkbox"/> MD / allopathic / Western medicine <input type="checkbox"/> Surgery <input type="checkbox"/> Medications <input type="checkbox"/> Chiropractic <input type="checkbox"/> Injections <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Naturopathic <input type="checkbox"/> Other:			
Name and phone of other practitioners who have treated you for your condition:			
Date of Last: Physical Exam:	Blood Test:	Urine Test:	Spinal Exam:
Spinal X-Ray:	Chest X-Ray:	Dental X-Ray:	MRI/CT-Scan:



PATIENT NAME:

TODAY'S DATE:

MEDICAL HISTORY

Check any of the following conditions you currently have, or have had in the past:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Chronic Fatigue Syndrome	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Pinched Nerve	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Tumors/growths
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Epstein Barr Virus	<input type="checkbox"/> Measles	<input type="checkbox"/> Polio	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Arthritis <input type="checkbox"/> Rheumatoid <input type="checkbox"/> Osteo	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Prostate Problem	<input type="checkbox"/> Vaginal Infections
<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Goiter	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Other (specify below)
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/>
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mumps	<input type="checkbox"/> Stroke	<input type="checkbox"/>
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Seizures	<input type="checkbox"/>
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Herpes Zoster ("shingles")	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid disorders	<input type="checkbox"/>

LIST ANY INJURIES AND/OR SURGERIES YOU'VE HAD	DATE
Falls	
Head Injuries	
Broken Bones	
Dislocations	
Surgeries	

EXERCISE	WORK ACTIVITY	HABITS
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking Packs/Day:
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol Drinks/Week:
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Coffee/Caffeine drinks Cups/day:
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High Stress Reason:

MEDICATIONS	ALLERGIES	VITAMINS / HERBS / MINERALS

I certify that the information on this 2-page form 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 provider, I understand that I am liable for all charges for services. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage.

Patient Signature:

Date:

PATIENT NAME:

TODAY'S DATE:

RESTRICTED MEDICAL HISTORY

The following medical history information has additional restrictions placed upon its release to third parties, and will not be disclosed to others unless you explicitly authorize it or we are otherwise ordered by legal authorities to release it:

Please check any of the following conditions you currently have, or have had in the past:

Addictions Yes No

If yes, too what substance?

If you have stopped using this, when did you stop?

AIDS / HIV Yes No

If Yes, Please give date of first diagnosis _____

and date of most recent lab work _____

Alcoholism Yes No

If Yes, how long? _____ Are you alcohol-free now? No Yes: since when?

Anorexia Yes No

Bulimia Yes No

Mental Health Disorder Yes No

If Yes, please describe:

Suicide Attempt Yes No

If Yes, how long ago?

Sexually Transmitted Disease(s) Yes No

If yes, please indicate which ones and when they occurred

Chlamydia

Gonorrhea

Genital Herpes

Genital Warts / HPV

NGU

Syphilis

Other

Domestic Violence or Abuse victim Yes No

ACUPUNCTURIST'S NOTES REGARDING INFORMATION ON THIS PAGE

Please leave the section below blank for your acupuncturist to fill out; these notes will also be restricted.