

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 Must 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,

Ear, Nose and Throat: Frequent Infections, stones, unable to hold urine,
 Other _____
 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.