Dorothy Pang L.Ac.

AcuSpa

333 El Camino Real Ste A
South San Fran, CA 94080
(650) 588-0888

(To be fill out in full by the practice member or parent/guardian)
If you have any questions of would like photocopies, please notify receptionist

Personal Information

Name _____ Preferred Name (if other) _____
Street Address _____
City _____ State _____ Zip _____
Home Phone # _____ Work # _____
Mobile/Other _____ Gender: ☐ F ☐ M
Marital Status _____ Referred by _____
Birthdate ____/____/_____ Age _____ Occupation

_____ Do you have medical insurance that covers acupuncture:

☐ Yes / ☐ No / ☐ Don't Know

Emergency Contact

Name _____ Relation _____
Phone Number(s) _____

Primary Care Physician's Information:

Physician Name _____ Phone # _____
Address (City) _____

Medical History

Are you presently being treated for any medical condition? ☐ Yes / ☐ No
What health issue(s) may we help you with? _____
Please list below any medicine, supplements, or herbs.
(Include birth control pills, multivitamins, antacids, laxative, diet pills, insulin, etc.)

Drug/Herb/Supplement	Amount	Why	How Long?

Please turn over and fill out back side of form

New Patient Form

Do you have any allergies? (pollen, food, drug) _____

Do you have any bleeding/clotting disorders? ☐ Yes / ☐ No

Please list below if you take any recreational drugs, smoke, or drink alcohol, along with amounts and how often:

_____

Please list date and type of any surgeries or hospitalizations below.

Date	Hospitalization / Surgery

Family History

Please indicate below if you or any immediate family members have the following:

Condition	Relation	Condition	Relation
Addictions		Diabetes	
Alzheimer's		Heart Disease	
Asthma		High Blood Pressure	
Blood Disorder		Seizure	
Cancer/Tumor		Stroke	

Please list any other conditions that may run in your family:

_____

General Lifestyle

How many glasses of water do you typically drink a day? ___ Tea/Coffee___ Soda___

How often do you exercise? _____

What type of exercise? _____

Would you like to receive periodic informative emails about once a month?
(We will not share your information with anyone)

☐ Yes; please write in email here_____ ☐ No Thanks

Signature_____ Date_____

Health History

Do you have any history of problems with...

1. ❑ Yes ❑ No - **Migraines**?
2. ❑ Yes ❑ No - **Headaches**?
3. ❑ Yes ❑ No - **Eyes**?
4. ❑ Yes ❑ No - **Ears**? *if Ringing,* is the pitch: ❑ high / ❑ low
5. ❑ Yes ❑ No - **Nose**?
6. ❑ Yes ❑ No - **throat**?

Notes for items 1-6: _____

7. ❑ Yes ❑ No - S**kin**? *if yes,* ❑ psoriasis / ❑ eczema / ❑ acne / ❑ dryness / ❑ other: _____ 8. ❑ Yes ❑ No - **Respiratory** system? *if yes,* please explain: ❑ asthma / ❑ allergies / ❑ other: _____
9. ❑ Yes ❑ No - **Chest** or breast area?
10. ❑ Yes ❑ No - **Neurological** system?
11. ❑ Yes ❑ No - **Digestive** system?
12. ❑ Yes ❑ No - **Urinary** system?
13. ❑ Yes ❑ No - **Reproductive** system?
14. ❑ Yes ❑ No - **Endocrine** system? *(Hormones)*

Notes for items 7-14: _____

15. ❑ Yes ❑ No - Do you have any **risk behaviors** we should be aware of? *if yes,* please explain: _____

Eating Habits

16. ❑ Yes ❑ No - I eat my meals at regular times.
17. What do you typically have for **breakfast**? _____
18. What do you typically have for a **mid-morning snack**? _____
19. What do you typically have for **lunch**? _____
20. What do you typically have for an **afternoon snack**? _____
21. What do you typically have for **dinner**? _____

Chinese Medicine Health History

22. I usually get ___ hours of **sleep** a night.
23. ❑ Yes ❑ No - I have trouble **falling asleep**.
24. ❑ Yes ❑ No - I have trouble **staying asleep**.
25. ❑ Yes ❑ No - I find that I **dream** very vividly, or have bad dreams.
26. ❑ Yes ❑ No - I find I have **less energy** than I should.
27. ❑ Yes ❑ No - I have a **high stress job**.
28. ❑ Yes ❑ No - I have a **high stress lifestyle**.
29. ❑ Yes ❑ No - I consider myself an **emotional** person. *if yes,* what emotions do you experience most o□en? _____
30. ❑ Yes ❑ No - I am constantly **thirsty**.
31. ❑ Yes ❑ No - I am almost **never thirsty**. *I prefer my liquids* ❑ hot / ❑ cold / ❑ room temp
32. ❑ Yes ❑ No - I experience **fevers** or **chills** other than when I am acutely ill.
33. ❑ Yes ❑ No - I am normally **hotter** than those around me.
34. ❑ Yes ❑ No - I am normally **cooler** than those around me.
35. ❑ Yes ❑ No - I easily get **cold hands** and /or **feet**.
36. ❑ Yes ❑ No - I have a **high appetite**.
37. ❑ Yes ❑ No - I have a **low appetite**.
38. ❑ Yes ❑ No - I experience **heartburn** (burning sensation in chest).
39. ❑ Yes ❑ No - I experience **acid reflux** (feeling of something rising in chest).
40. ❑ Yes ❑ No - I experience **night sweats**.
41. ❑ Yes ❑ No -I experience **spontaneous sweating**.
42. ❑ Yes ❑ No - I am on a special **diet**. If yes, explain: _____
43. ❑ Yes ❑ No - I experience food **cravings**. If yes, for what? _____
44. ❑ Yes ❑ No - I experience irregularity in **bowel movements**.
45. ❑ Yes ❑ No - My bowel movements are **not well formed**.
46. ❑ Yes ❑ No - My bowel movements are **uncomfortable**.
47. ❑ Yes ❑ No - I experience **painful urination**.
48. ❑ Yes ❑ No - I experience **frequent urination**.
49. ❑ No ❑ Yes - I am happy with my **libido**.

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Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you may access this information. Please review it carefully.

At AcuSpa, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use and disclose your health information to those involved in your treatment and in normal healthcare operations. For example, one of our staff may enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or voicemail or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all your health information when required by law. If this practice is sold, your information will become property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request that we not disclose your health information as above. We will let you know if we are able to fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. We will transmit your information for you, for a nominal processing fee.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for your copies. You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment of change, we will not remove or alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Ave, SW, Rm 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our privacy officer, Dorothy Pang at 650.588.0888.

This notice goes into effect as of January 1, 2014.

Acknowledgement

I have received a copy of Dorothy's Notice of Privacy Practices.

Signed_____Print Name_____Date_____

24 hour Cancellation Policy

By keeping your appointments you ensure that you get the best treatment results while also ensuring that your wait times are kept to a minimum.

For your appointment, we set aside one hour of our time for you. We kindly request that you make every effort to keep your appointment.

If you need to move your appointment time within the same day and there is availability, we will be happy to do so without charge. If you miss an appointment, or there is less than 24 notice for a cancellation, there will be a **$30** fee.

Thank you for your consideration.

I acknowledge that I have read and agree to the 24 hour cancellation policy.

Signed by: _____ Date: _____

Health History

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We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or voicemail or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all your health information when required by law. If this practice is sold, your information will become property of the new owner.

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