



2525 N. Grand Ave., Suite Z
Santa Ana, CA, 92705
Phone: 657-464-4228

Patient Confidential Information

1. Name _____
First Middle Last

2. Address _____
Street City State Zip

3. Home Phone _____ 4. Business Phone _____

5. Cell _____ 6. Email _____

7. Age _____ 8. Date of Birth _____ 9. Sex _____ 10. Marital: M S D W

11. Social Security No _____ 12. Driver's License No _____

13. Occupation _____ 14. Employer _____

Employer's Address _____
Street City St. Zip

15. In case of emergency, call: _____
Name Phone

FOR MINORS: List both parents' names and addresses

Guardian or Spouse's Signature of Authorizing Care _____

FINANCIAL ARRANGEMENTS

How do you plan to handle your account? (Check one) Cash Check

PATIENT HEALTH HISTORY

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care? _____

For what reason? _____

2. Has your case been referred to an attorney? Y N

3. Please identify the health concerns that have brought you to Four Pillars Acupuncture Clinic in order of importance below:

Condition

Past Treatment

a. _____

How does this condition affect you? _____

b. _____

How does this condition affect you? _____

c. _____

How does this condition affect you? _____

d. _____

How does this condition affect you? _____

4. Is there anyone else in your family that has health problems, even if they are not the same as yours?

Who	What problem	Care they are receiving	Local? (Y/N)
_____	_____	_____	_____
_____	_____	_____	_____

5. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

6. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

7. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

8. Do you have any infectious diseases? Y N If yes, please identify: _____

9. Family History:

Check those applicable:

Age (if living) _____

Health

	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Children</u>
	_____	_____	_____	_____	_____	_____
	<input type="checkbox"/> Good <input type="checkbox"/> Poor	<input type="checkbox"/> Good <input type="checkbox"/> Poor	<input type="checkbox"/> Good <input type="checkbox"/> Poor	<input type="checkbox"/> Good <input type="checkbox"/> Poor	<input type="checkbox"/> Good <input type="checkbox"/> Poor	<input type="checkbox"/> Good <input type="checkbox"/> Poor
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Hay fever/Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

10. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

11. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

12. **Childhood Illness** (please check any that you have had):

- | | |
|---|---|
| <input type="checkbox"/> Scarlet Fever/Diphtheria | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> German Measles |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Chicken Pox |

13. **Immunizations** (please check any that you have had):

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Polio | <input type="checkbox"/> Diphtheria |
| <input type="checkbox"/> Tetanus | <input type="checkbox"/> Hib |
| <input type="checkbox"/> Rubella/Mumps/Rubella | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Pertussis | |

Others: _____

14. **Hospitalizations and Surgeries:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

15. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____

Symptoms: (please check any that you experience now and underline any that you have experienced in the past):

16. **Emotional:**

- | | | |
|--------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Mental Tension |
|--------------------------------------|--------------------------------------|---|

17. **Energy and Immunity**

- | | |
|---|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Chronic Infections |
| <input type="checkbox"/> Slow Wound Healing | <input type="checkbox"/> Chronic Fatigue Syndrome |

18. Head, Eye, Ear, Nose, and Throat

- Impaired Vision
- Eye Pain/Strain
- Glaucoma
- Glasses/Contacts
- Tearing/Dryness
- Impaired Hearing
- Ear Ringing
- Earaches

- Headaches
- Sinus Problems
- Nose Bleeds
- Frequent Sore Throats
- Teeth Grinding
- TMJ/Jaw Problems
- Hay Fever

19. Respiratory

- Pneumonia
- Frequent Common Colds
- Difficulty Breathing
- Emphysema
- Persistent Cough
- Pleurisy

- Asthma
- Tuberculosis
- Shortness of Breath
- Other Respiratory Problems:

20. Cardiovascular

- Heart Disease
- Chest Pain
- Swelling of Ankles
- High Blood Pressure
- Palpitations/Fluttering

- Stroke
- Heart Murmurs
- Rheumatic Fever
- Varicose Veins

21. Gastrointestinal

- Ulcers
- Changes in Appetite
- Nausea/Vomiting
- Epigastric Pain
- Passing Gas
- Heartburn

- Belching
- Gall Bladder Disease
- Liver Disease
- Hepatitis B or C
- Hemorrhoids
- Abdominal Pain

22. Genito-Urinary Tract

- Kidney Disease
- Painful Urination
- Frequent UTI
- Frequent Urination
- Heavy Flow

- Kidney Stones
- Impaired Urination
- Blood in Urine
- Frequent Urination at Night

23. Female Reproductive/Breasts

- Irregular Cycles
- Breast Lumps/Tenderness
- Nipple Discharge
- Heavy Flow
- Vaginal Discharge
- Premenstrual Problems

- Clotting
- Bleeding Between Cycles
- Menopausal Symptoms
- Difficulty Conceiving
- Painful Periods

24. Menstrual/Birthing History:

1. Age of First Menses: _____
2. # of Days of Menses: _____
3. Length of Cycle: _____

4. Birth Control Type: _____
5. # of Pregnancies: _____
6. # of Miscarriages: _____

7. # of Abortions: _____
8. # of Live Births: _____

25. **Male Reproductive**

- Sexual Difficulties
- Prostrate Problems
- Testicular Pain/Swelling
- Penile Discharge

26. **Musculoskeletal**

- Neck/Shoulder Pain
- Muscle Spasms/Cramps
- Arm Pain
- Upper Back Pain
- Mid Back Pain
- Low Back Pain
- Leg Pain
- Joint Pain (if so, where?): _____

27. **Neurologic**

- Vertigo/Dizziness
- Paralysis
- Numbness/Tingling
- Loss of Balance
- Seizures/Epilepsy

28. **Endocrine**

- Hypothyroid
- Hypoglycemia
- Hyperthyroid
- Diabetes Mellitus
- Night Sweats
- Feeling Hot or Cold

29. **Other**

- Anemia
- Cancer
- Rashes
- Eczema/Hives
- Cold Hands/Feet

Is there anything else we should know? _____

30. **Lifestyle:**

- a. Exercise routine: _____
- b. Spiritual practice: _____
- c. Level of education completed: High School Bachelors Masters Doctorate Other
- d. Nicotine/Alcohol/Caffeine Use: _____
- e. Have you experienced any major traumas? Y N Explain: _____
- f. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____
- g. Interests and hobbies: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.

DATED _____ PATIENT'S SIGNATURE _____
(parent's signature if patient is minor)

How did you hear about us? _____
Would you like to receive our email newsletter? _____