



Sally Chang, L.Ac. DNBAO
Acupuncturist & Herbalist

PLEASE PRINT

Name: _____ Birth Date: ____/____/____
Name of Parent or Guardian: _____ Social Security# _____
Street Address: _____ Gender: _____
City, State, Zip: _____

Phone: (h) _____ (c) _____ (w) _____
email: _____

Occupation: _____ Marital Status: (circle) Single Married Partnered Other

Emergency Contact : _____ Tel: _____

Emergency Contact's Relationship: _____

Personal or Referring Physician: _____ Physician's Tel: _____

Are you are currently being treated elsewhere? (circle) Y N For what complaint? _____

Provider's name: _____ Provider's Tel: _____

Please list any medications you are currently taking: _____

Please list any herbs and/or supplements you are currently taking: _____

Have you received Acupuncture before? (circle) Y N

How did you hear about Sally Chang, L.Ac.? _____

MEDICAL HISTORY:

➔ Please check all that apply to your health history, include date and description

- | | | |
|---|--|---|
| <input type="checkbox"/> Arthritis: OA__ RA__ | <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> HIV + |
| <input type="checkbox"/> Abortion: #__ | <input type="checkbox"/> Diabetes (DM): type__ | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Allergies: _____ | <input type="checkbox"/> Digestive disorder: _____ | <input type="checkbox"/> Injuries: _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emotional difficulties: _____ | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Irregular Pregnancy: _____ |
| <input type="checkbox"/> Back Pain: upper__ mid__ low__ | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Joint Pain/Problem: _____ |
| <input type="checkbox"/> Birth Control Pills #yrs__ | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Lyme Disease |
| <input type="checkbox"/> Birth complications: _____ | <input type="checkbox"/> Gout | <input type="checkbox"/> Mammogram: #__ |
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Headaches | <input type="checkbox"/> Menstrual irregularity |
| <input type="checkbox"/> Blood Pressure, High | <input type="checkbox"/> Heart Attack (MI) | <input type="checkbox"/> Pregnancy #__ |
| <input type="checkbox"/> Blood Pressure, Low | <input type="checkbox"/> Heart Problems: _____ | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis A__ B__ C__ | <input type="checkbox"/> Surgeries: _____ |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Herpes Simplex 1__ 2__ | <input type="checkbox"/> Thyroid problem: _____ |
| <input type="checkbox"/> Cholesterol, High | <input type="checkbox"/> Herpes Zoster/Shingles | <input type="checkbox"/> OTHER: _____ |

MAJOR COMPLAINT: Briefly describe your major health complaint or/and describe details from above.

LIFESTLYE: Which of the following are a part of your lifestyle?

- | | | |
|---|--|--|
| <input type="checkbox"/> Tobacco _____ | <input type="checkbox"/> Recreational drugs | <input type="checkbox"/> Relaxation/Meditation |
| <input type="checkbox"/> Coffee drinking | <input type="checkbox"/> Special Diet: _____ | |
| <input type="checkbox"/> Alcohol drinking | <input type="checkbox"/> Exercise: _____ | |

FAMILY MEDICAL HISTORY: Please name and date the onset & resolution of any major illness such as Heart Disease, Diabetes, High/Low Blood Pressure, Cancer, Neurological or Psychological disorders

| | Living | Deceased | | Name of illness', Date, Additional information |
|-------------|--------------------------|--------------------------|----------|--|
| Mother | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Father | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Sibling | <input type="checkbox"/> | <input type="checkbox"/> | F M | |
| Sibling | <input type="checkbox"/> | <input type="checkbox"/> | F M | |
| Sibling | <input type="checkbox"/> | <input type="checkbox"/> | F M | |
| Grandmother | <input type="checkbox"/> | <input type="checkbox"/> | Maternal | |
| Grandfather | <input type="checkbox"/> | <input type="checkbox"/> | Maternal | |
| Grandmother | <input type="checkbox"/> | <input type="checkbox"/> | Paternal | |
| Grandfather | <input type="checkbox"/> | <input type="checkbox"/> | Paternal | |
| Other: | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Other: | <input type="checkbox"/> | <input type="checkbox"/> | | |

OFFICE POLICY:

All fees for medical services are due at the time services are rendered. If you have insurance which covers acupuncture, we will be happy to assist you in preparing your claim.

If you need to change or cancel an appointment please give a minimum 24 hour notice to avoid a late fee for the full amount for the appointment.

I have received and understand the Notice of Privacy Practices.

My signature authorizes Sally Chang, L.Ac. to treat me (or the patient for whom I am legally responsible) with Acupuncture, herbs and modalities within the licensure granted by the Department of Consumer Affairs and the California Acupuncture Board. 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. I authorize the release of any medical or other information necessary for insurance claim processing.

Signature: _____
 (Patient, Parent, Guardian)

Date: _____

For Clinic purposes only:

Witness to Patient's signature: _____
 (Staff member)

Date: _____