Acubalance Clinic
Acupuncture Health Solutions

1201 S. Beach Blvd., Suite 102, La Habra, CA 90631

Phone : 562-902-1010 www.acubalnaceclinic.com

**Please Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.**

Name _____ Date_____

Street_____ Home Phone _____

City _____St ____ Zip _____ Mobile Phone_____

Age_____ Birth Date_____ E-mail address_____

Sex ☐ M ☐ F Social Security No. _____ Driver's License No. _____

Marital Status: ☐ M ☐ S ☐ D ☐ W Employer _____ Occupation _____

Name of person we should contact in event of an emergency :

Name_____Phone_____Relationship_____

How were you referred to this clinic _____

Payment will be made by : ☐ Self-paid ☐ P. I. ☐ Health Ins. ☐ Worker's Com. ☐ Others _____

Who is responsible for Insurance account ?_____ Birth date_____SS#_____

Relationship to patient_____ Insurance Co. _____ Group # _____

**MAIN REASON FOR COMING** _____

When did it begin? (Date) _____What caused it ? _____

How often are you symptoms present ? ☐ Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally

Work-related ? ☐ Y ☐ N ☐ DK Accident ? ☐ Y ☐ N What kind? _____

What makes it better ?☐ Heat ☐ Cold ☐ Activity ☐ Rest Other _____

What makes it worse? ☐ Heat ☐ Cold ☐ Activity ☐ Rest Oother _____

Is it getting worse ? ☐ Y ☐ N Does it interfere with? ☐ work ☐ sleep ☐ daily routine

Have you received treatment for this problem ? ☐ Y ☐ N

| If yes : Who? | When? | Treatment | Did it help? |
|---|---|---|---|
| _____ | _____ | _____ | ☐ Y ☐ N |
| _____ | _____ | _____ | ☐ Y ☐ N |

**OTHER REASONS FOR COMING** _____

**AREAS OF PAIN**

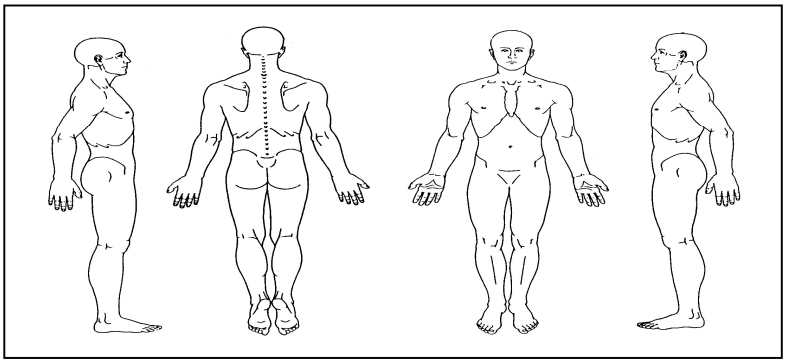
Please indicate the location of the pain/discomfort by using the symbol that best describes the feeling :

+++ Sharp/Stabbing

? ? ? Pins/Nneedles

v v v Dull/Aching

/ / / Numbness



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## ILLNESSES / INJURIES

Have you ever had the following? Check all that apply:

- ☐ AIDS
- ☐ Alcoholism
- ☐ Allergies/hay fever
- ☐ Anemia
- ☐ Arthritis/gout
- ☐ Artificial joint
- ☐ Asthma
- ☐ Auto accident/injury
- ☐ Bleeding/bruising problem
- ☐ Breast lump
- ☐ Broken bone
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Chicken pox
- ☐ Colitis or bowel disease
- ☐ Concussion
- ☐ Convulsions/epilepsy
- ☐ Diabetes
- ☐ Diptheria
- ☐ Dislocations
- ☐ Diverticulitis
- ☐ Eczema/hives
- ☐ Emphysema/COPD
- ☐ Epilepsy
- ☐ Food, chemical, or drug
- ☐ Gallstone/gallbladder disease
- ☐ Heart disease
- ☐ Hepatitis A B C
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ High blood pressure
- ☐ Hypoglycemia
- ☐ Frequent infections
- ☐ Influenza
- ☐ Kidney/bladder problems
- ☐ Lifting injuries
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Neuritis or neuraligia
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Paralysis
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problems
- ☐ Psoriasis
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Sprains
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers/stomach disease
- ☐ Venereal disease
- ☐ Whooping cough

## HOSPITALIZATIONS / SURGERIES

Have you been hospitalized for any illness? ☐ N ☐ Y

Reason _____ Month/Year _____ Where _____

Have you ever had surgery? Give year or age:

Tonsils _____ Appendix _____ Hysterectomy _____ Gall Bladder _____

Kidney _____ Heart _____ Hernia _____ Back/spine _____

Prostate _____ Cyst _____ Cancer _____

Breast _____ Other _____

Have you ever had a blood or plasma transfusion? ☐ N ☐ Y

## MEDICATIONS

List medications you are currently taking _____

## ALLERGIES / SENSITIVITIES _____

## WOMEN'S HEALTH

Are you pregnant? ☐ Y ☐ N

Menstrual History

Menstrual Symptoms

What methods of birth control are you now using or have used in the past?

Birth History

## MEN'S HEALTH

- ☐ Burning or discharge from penis
- ☐ Painful testicles
- ☐ Lumps or swelling on testicles
- ☐ Ejaculation pain
- ☐ Premature ejaculation
- ☐ Sores on penis or scrotum
- ☐ Varicose veins in scrotum
- ☐ Low sperm count
- ☐ Low sex drive
- ☐ Erection problems
- ☐ Prostate problems

**To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child, ever have a change in health.**

| **Patient's Name** (Please Print) | **Date** |
|---|---|
| **Patient Signature** (or Patient's Representative) | (Indicate relationship if signing for Patient) |