Anita Lang-Bakar, L.Ac.

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Patient Medical History

Patient Information

Name _____ Date _____

Street Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Office Phone _____

Other Phone _____ E-mail _____

Birth Date _____ Age _____ Soc. Sec. _____Gender _____

□ Single □ Married □ Divorced □ Widowed □ Domestic Partnership □ Other

Emergency Contact _____ Relationship _____

Emergency Contact Phone _____ Office/Cell _____

Physician's Name _____ Phone _____

Physician's Address _____ Date of last visit _____

Employment: Please check all that apply

□ Full-time □ Part-time □ Self-employed □ Student □ Unemployed □ Retired

Occupation _____ Number of hours of work/study per week _____

Employer's Name _____

Phone _____

Employer's Address

_____

_____

Spouse/Domestic Partner Name _____

Spouse/Domestic Partner Employer's Name _____

Phone _____

Employer's Address

_____

_____

Billing and Insurance

Account Paid by □ Self □ Workmen's Comp □ Other

Primary Insurance _____

Phone _____

Primary Insurance Address _____

Policy Holder's Name _____ Relationship _____

Policy# / ID _____Group # _____

Secondary Insurance Phone # _____

Secondary Insurance Address _____

Policy Holder's Name _____ Relationship _____

Policy# / ID _____Group # _____

Have you ever had an acupuncture treatment? When and for what reason?

_____

_____

_____

Are you presently being treated for a medical condition? Please describe.

_____

_____

_____

What health issue(s) do you want to be treated for? Please describe as fully as possible.

_____

_____

What treatment (if any) have you been using for relief of this issue?

_____

Do you have other health concerns? If so, please describe.

_____

Please describe the types of foods you eat regularly.

Breakfast _____

Lunch _____

Dinner _____

Snacks/other meals _____

Let us know how you feel about the following areas of your life. Please mark the appropriate description and indicate any problems you may be experiencing.

Spouse/Partner □ Great □ Good □ Fair □ Poor □ Bad _____

Family □ Great □ Good □ Fair □ Poor □ Bad _____

Diet □ Great □ Good □ Fair □ Poor □ Bad _____

Sex □ Great □ Good □ Fair □ Poor □ Bad _____

Self □ Great □ Good □ Fair □ Poor □ Bad _____

Work □ Great □ Good □ Fair □ Poor □ Bad _____

Family History - Please check **all** that are appropriate.

	Self	Mother	Father	Sister	Brother	Child	Grandparent
Allergies							
Blood disorder/Anemia							
Diabetes							
Cancer or Tumors							
Seizures							
High Blood Pressure							
Kidney or Bladder disorder							
Stomach or intestinal disorder							
Drug Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression/Mental Illness							
Other							
Age at death							

Habits - Please check any habits that apply to you now or in the past

Coffee	□ Yes □ No	per day/week ____	age started ____	age quit ____
Tobacco	□ Yes □ No	per day/week ____	age started ____	age quit ____
Alcohol	□ Yes □ No	per day/week ____	age started ____	age quit ____
Cocaine	□ Yes □ No	per day/week ____	age started ____	age quit ____
Heroin	□ Yes □ No	per day/week ____	age started ____	age quit ____
Marijuana	□ Yes □ No	per day/week	age started	age quit

Major Hospitalizations

Please list any hospitalizations or surgeries you have undergone.

Operation/Illness _____ Year _____

Name of hospital _____

City _____ State _____

Operation/Illness _____ Year _____

Name of hospital _____

City _____ State _____

Operation/Illness _____ Year _____

Name of hospital _____

City _____ State _____

Medicines, Herbs and Supplements - Check any medications you are currently taking.

□ Aspirin □ Ibuprofen (Advil) □ Acetaminophen(Tylenol) □ Antacids □ Laxatives □ Cold tablets

□ Oral contraceptives □ Tranquilizers □ Sleeping Pills □ Diet Pills

□ Allergy Medicine □ Blood pressure Meds □ Blood thinning medication □ Insulin/diabetes Medication

Western Drugs _____

Herbs _____

Supplements _____

Allergies □ Yes □ No

To Medication :_____

To Food :_____

Additional Information

Symptoms/Concern - Please mark all that apply.

Musculo-Skeletal

Joint Pain
□ Past □ Current: Location _____

Muscular Pain
□ Past □ Current: Location _____

Strain
□ Past □ Current: Location _____

Broken Bone(s)
□ Past □ Current: Location _____

Atrophy
□ Past □ Current: Location _____

Localized Weakness
□ Past □ Current: Location _____

Numbness/Tingling of Limbs
□ Past □ Current: Location _____

Area of Pain

Neck
□ Past □ Current

Shoulder
□ Past □ Current □ Right □ Left

Arm
□ Past □ Current □ Right □ Left

Elbow
□ Past □ Current □ Right □ Left

Wrist
□ Past □ Current □ Right □ Left

Hand
□ Past □ Current □ Right □ Left

Fingers
□ Past □ Current □ Right □ Left

Chest
□ Past □ Current

Rib/Flank
□ Past □ Current □ Right Side □ Left Side

Abdomen
□ Past □ Current □ Upper Abdomen □ Lower Abdomen
□ Right Side □ Left Side

Back Pain
□ Past □ Current □ Upper Back □ Mid Back □ Low Back

Hip
□ Past □ Current □ Right □ Left

Leg
□ Past □ Current □ Thigh □ Shin
□ Calf □ Right □ Left

Knee
□ Past □ Current □ Right □ Left

Ankle
□ Past □ Current □ Right □ Left

Foot
□ Past □ Current □ Right □ Left

Heel
□ Past □ Current □ Right □ Left

Toes
□ Past □ Current □ Right □ Left

_____

General

Overall energy
□ Good □ Fair □ Poor

Low Energy/Fatigue
□ Past □ Current □ Time of day_____

Body Temperature Changes

□ Past □ Current: □ Tend to be Cold □ Tend to be Warm

Spontaneous Sweating with NO exertion
□ Past □ Current Location _____

Night Sweats
□ Past □ Current

Fevers **Chills**
□ Past □ Current □ Past □ Current

Appetite Changes
□ Past □ Current: □ Decreased/Poor □ Increased

Food Cravings
□ Sweet □ Sour □ Salty □ Spicy

Thirst/Drink Preference
□ Always Thirsty □ Don't drink enough

□ Prefer Warm □ Prefer Cold □ Room Temperature

Sleep
□ Good □ Fair □ Poor

Insomnia
□ Past □ Current

□ Difficulty Falling asleep □ Difficulty staying asleep

Excessive/Vivid Dreams
□ Past □ Current

Tumors/Lumps
□ Past □ Current Location:

Head/Neck/Eyes/Ears

Ear Ringing
□ Past □ Current: □ High Pitched □ Low Pitched

Decreased/Loss of Hearing
□ Past □ Current

Ear Infections
□ Past □ Current

Eye Problems
□ Past □ Current: □ Redness □ Dryness □ Spots

□ Excessive Tears

Vision Changes
□ Past □ Current □ Glasses/Contacts

Blurred Vision
□ Past □ Current

Poor Night Vision
□ Past □ Current

Neck Stiffness

□ Past □ Current

Concussion(s)
□ Past □ Current

Whiplash
□ Past □ Current

Poor Memory
□ Past □ Current

Concentration
□ Good □ Poor

Migraines/HA

□ Past □ Current Location:_____

Dizziness/Light-headed
□ Past □ Current

Fainting
□ Past □ Current

Neurological

Seizures
□ Past □ Current

Numbness/Tingling of Limbs
□ Past □ Current: Location _____

Tremors
□ Past □ Current

Pain
□ Past □ Current

Paralysis
□ Past □ Current: Location _____

Cardiovascular

High Blood Pressure / Low Blood Pressure
□ Past □ Current

High Cholesterol
□ Past □ Current

Phlebitis/Inflammation of Veins
□ Past □ Current

Blood Clots
□ Past □ Current

Palpitations
□ Past □ Current

Irregular Heart Beat
□ Past □ Current

Chest Pain/Pressure

□ Past □ Current

Poor Circulation

□ Past □ Current: □ Cold Feet □ Cold Hands

Edema/Swelling
□ Past □ Current: □ Feet □ Hands

Tests / Medications:

Psychological

Depression
□ Past □ Current

Anxiety/Stress
□ Past □ Current

Panic Attacks
□ Past □ Current

Eating Disorder
□ Past □ Current

Irritability
□ Past □ Current

Anger
□ Past □ Current

Addictions
□ Past □ Current To What _____

Treated for Emotional/Psychological Issues
□ Past □ Current For What _____

Medications:

Gastro-Intestinal

Indigestion/Heartburn
□ Past □ Current

Gas/Bloating
□ Past □ Current

Belching
□ Past □ Current

Abdominal Pain/Cramping
□ Past □ Current

Bad Breath
□ Past □ Current

Ulcers
□ Past □ Current

Nausea
□ Past □ Current

Vomiting
□ Past □ Current

Diarrhea
□ Past □ Current

Constipation
□ Past □ Current

Bloody Stools
□ Past □ Current

Hemorrhoids
□ Past □ Current

Rectal Pain
□ Past □ Current

Nose/Throat/Mouth

Gum Problems
□ Past □ Current

Teeth Problems
□ Past □ Current

Teeth Grinding
□ Past □ Current □ Use of Mouth guard

Frequent Sore Throat
□ Past □ Current

Difficulty Swallowing
□ Past □ Current

Dry Mouth/Throat
□ Past □ Current □ Day □ Night

Laryngitis
□ Past □ Current

Hoarse Voice
□ Past □ Current

Nose Bleeds
□ Past □ Current

Sinus Infection
□ Past □ Current

Hay fever/Allergies
□ Past □ Current

Respiratory

Frequent Colds
□ Past □ Current

Cough
□ Past □ Current □ Worse at night □ Worse during day

Cough with Blood
□ Past □ Current

Production of Phlegm
□ Past □ Current

Asthma
□ Past □ Current

Bronchitis
□ Past □ Current

Pneumonia
□ Past □ Current

Chronic Obstructive Pulmonary Disease (CPOD)
□ Past □ Current

Emphysema
□ Past □ Current

Skin/Hair

Dry Skin
□ Past □ Current

Itchy Skin
□ Past □ Current

Acne
□ Past □ Current

Rashes
□ Past □ Current

Hives
□ Past □ Current □ Cause _____

Eczema
□ Past □ Current

Herpes
□ Past □ Current □ Type 1 □ Type 2

Shingles
□ Past □ Current

Psoriasis
□ Past □ Current

Hair Loss
□ Past □ Current

Genito-Urinary

Urgent Urination
□ Past □ Current

Painful Urination
□ Past □ Current

Unable to Hold Urine/Incontinence
□ Past □ Current

Weak Urine Stream
□ Past □ Current

Blood in Urine
□ Past □ Current

Kidney Stones
□ Past □ Current

Male Reproductive

Impotence
□ Past □ Current

Premature Ejaculation
□ Past □ Current

Testicular Lumps/Masses
□ Past □ Current

Genital Itching/Pain
□ Past □ Current

Genital Lesions/Discharge
□ Past □ Current

Weak Urinary Stream
□ Past □ Current

Decreased/Excessive Libido
□ Past □ Current

Female Gynecology

Urinary Tract Infection (UTI)
□ Past □ Current □ Frequent

Pelvic Inflammatory Disease (PID)
□ Past □ Current

Vaginal Infections / Yeast Infections
□ Past □ Current

Genital Itching/Pain
□ Past □ Current

Genital Lesions/Discharge
□ Past □ Current

Irregular Periods
□ Past □ Current □ Early □ Delayed

Premenstrual Syndrome (PMS)
□ Past □ Current: □ Symptoms _____

Painful Periods / cramps
□ Past □ Current

Bleeding
□ Heavy □ Light □ Spotting

Menopausal Symptoms
□ Past □ Current □ Symptoms _____

Decreased/Excessive Libido
□ Past □ Current

Breast Lumps/Pain
□ Past □ Current

Date of last Period: _____

Pregnancies:

Total Pregnancies____ Living___

Ectopic____Miscarriages____Induced Abortions___

Age at onset of Menarche ____

Age at onset of Menopause ____

Health Screening/Testing

HIV
□ Past □ Current: _____

Tuberculosis (TB)
□ Past □ Current : _____

Hepatitis
□ Past □ Current: _____

STD

□ Past □ Current: _____

Patient Treatment Informed Consent Agreement

Name_____ Date of Birth_____

I hereby give my consent for Anita Lang-Bakar, L.Ac with Driftwood Acupuncture & Wellness to perform treatment utilizing Traditional Chinese Medicine techniques.

I understand that the techniques utilized in Chinese Medicine and by Driftwood Acupuncture & Wellness are not experimental, but backed by over 3 thousand years of clinical experience in China and used successfully in the West. These practices are accepted therapy recognized by the State of California. The methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (Chinese Massage), Guasha (scraping technique), Chinese Herbal Medicine, and nutritional counseling.

I understand that all acupuncture or other Traditional Chinese treatments will be performed by a CA State licensed acupuncturist.

I understand that all needles utilized for the acupuncture treatments are pre-packaged, sterile, single-use needles that have never before been used and will be discarded after each treatment.

Although the clinic uses sterile, disposable needles and maintains a clean and safe environment, infection is another possible risk of treatment. Risks associated with moxibustion treatment may include burns and/or scarring, although unusual and rare. I understand that while this document describes major risks of treatment, other unanticipated side effects may occur. I do not expect the acupuncturist to be able to anticipate all possible complications from treatment, but I do wish to rely on the acupuncturist to exercise judgment during the course of treatment, which based upon the facts known and my condition, is in my best interests.

Initial _____ Date _____

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are safe in the practice of Chinese Medicine, although some may be toxic if not taken as prescribed. Other possible side effects of herbal treatments are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that some herbs may be inappropriate during pregnancy.

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided verbally and in writing. The herbs may have an unpleasant taste or smell. I will immediately notify my practitioner of any unpleasant effects associated with the consumption of herbal teas or products.

• I will notify Anita Lang-Bakar, L.Ac if I am or become pregnant.

• I agree to follow all treatments only as recommended/prescribed. If I am experiencing any side effects or difficulties I will notify practitioner as soon as possible.

• I understand the practitioner and clinic staff may review my lab reports, but all my records will be kept strictly confidential and will not be released without my consent.

Initial _____ Date _____

Privacy Policy
I understand that the clinical and medical staff may review my files but all my records will be kept confidential and can only be released under my personal written consent or when required by law.

Initial _____ Date _____

Cash and Personal Insurance Financial Agreement
We would like to take a moment to welcome you to our office and familiarize you with our financial policies.

You are financially responsible for all services rendered to you in this office. Payment is made in full (100%) for each visit at the time of visit unless special arrangements have been made with your provider.

Cancellation Policy
No charge will be made for cancellations or appointment changes if 24 hours notice is given. For cancellations with less than 24 hours full price will be charged. Payments need to be made in full by you.

I hereby certify that I have read (or have had it read to me) and understand the above consent form. This consent form shall cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment. I may have a copy of this form for my records.

Signature _____ Date:_____
(Patient/Representative)

Clinician _____ Date:_____
(Anita Lang-Bakar, L.Ac.)