Anita Lang-Bakar, L.Ac.

3727 Buchanan Street, Suite 204
San Francisco, CA 94123
415-570-1527
www.driftwoodacu.com

Patient Medical History & Intake Form

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

Referred to out Clinic by:_____

Emergency Contact _____Relationship _____

Emergency Contact Phone _____ 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_____

Billing and Insurance Account Paid by □ Self □ Workmen's Comp □ Other

Primary Insurance Company: _____ Tel#: _____

Primary Insurance Address _____

Policy Holder's Name _____ Relationship _____

Policy Holder's Date of birth _____

Policy# / ID _____Group # _____

Plan _____

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 at each meal and during the day:

Breakfast _____

Lunch _____

Dinner _____

Snacks/other meals _____

Do you Exercise Regularly? □ Yes □ No How Frequently?_____ times per day / week

What type of Exercise do you do?

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 by marking with an X

	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	cups per day/week:	age started ____ age quit ____
Tobacco	□ Yes □ No	cigarettes per day/week:	age started ____ age quit ____
Alcohol	□ Yes □ No	Drinks per day/week:	age started ____ age quit ____
Cocaine	□ Yes □ No	use per day/week ____	age started ____ age quit ____
Heroin	□ Yes □ No	use per day/week ____	age started ____ age quit ____
Marijuana	□ Yes □ No	use per day/week ____	age started ____ age quit ___
Other:			

Major Hospitalizations - Please list any hospitalizations or surgeries you have undergone.

Year	Operation or illness	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 □ Allergy Medicine
□ Diet Pills □ Tranquilizers □ Sleeping Pills □ Oral contraceptives
□ Blood pressure Pills □ Blood thinning medication □ Insulin/diabetes pills □ Fiber Supplements
□ Other: (Please List name of drug & Dosage)

_____

Vitamins & Supplements (Please List)

_____

Herbs (Please List)

_____

+ + **Allergies** □ Yes □ No

To Medication:

To Food:

Latex or other:

Additional Information:

Symptoms/Concerns Please mark all that apply

Musculo-Skeletal

Injury
□ Past □ Current: Location _____

Joint Pain
□ Past □ Current: Location _____

Muscular Pain
□ Past □ Current: Location _____

Strain
□ Past □ Current: Location _____

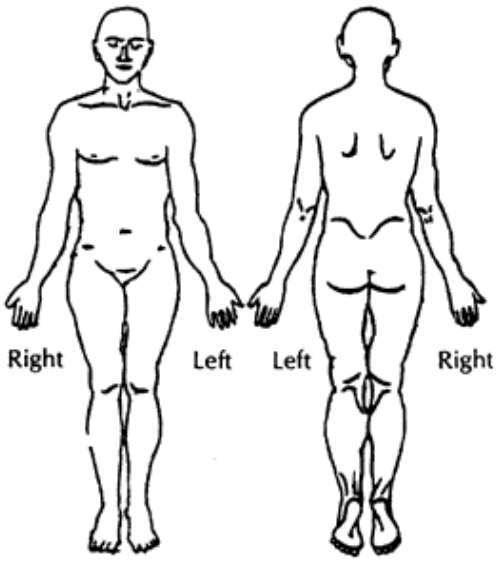
Broken Bone(s)
□ Past □ Current: Location _____

Atrophy
□ Past □ Current: Location _____

Localized Weakness
□ Past □ Current: Location _____

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

Area of Pain (Please circle the area of concern)



Quality of Pain: (circle appropriate)

Sharp - shooting / dull - achy

Cause: _____

Onset: _____

Worse with: _____

Better with: _____

Have you seen a specialist?

_____

Lab tests / X-Ray / MRI /Scan (circle)

Date:

Explanation of Pain:

_____

_____

_____

_____

_____

_____

_____

Medication you've been given for this condition:

_____

Better / unchanged / worse (Circle one)

General *(Check box or circle when applicable)*

Overall energy Good Fair Poor
Time of day when lowest?

Body temperature
□ tend to run cold □ tend to run warm
□ Cold hands □ Cold feet
□ Sweats easily □ Night sweats
□ Chills □ Fevers

Past Current
□ □ Increased Appetite
□ □ Decreased appetite
□ □ Weight Gain / Loss
Food Cravings: Sweet Sour Salty Spicy
□ □ Strong thirst
□ □ Lack of thirst
Preference: Cold Warm Hot Room Temp
□ □ Eating disorder

Sleep
Good Fair Poor Average hours of sleep:

Past Current
□ □ Difficulty Falling asleep
□ □ Difficulty staying asleep
□ □ Get up to go to bathroom (#)
□ □ Vivid Dreams
□ □ Insomnia
□ □ Sleep Apnea
□ □ Clench Jaw / Grind teeth (Mouth guard?)

Psychological
Past Current
□ □ Depression
□ □ Anxiety / Stress
□ □ Panic Attacks
□ □ Irritability / Anger
□ □ Addictions
To what:
□ □ Treated for Emotional / Psychological Issues
For what:

Head & Neck
Past Current
□ □ Concussion / Whiplash (date_____)
□ □ Dizziness / Fainting / light headed
□ □ Neck stiffness
□ □ Enlarged lymph nodes
□ □ Poor Memory / difficulty concentrating
□ □ Recurrent Headaches / migraines

Eyes
Past Current
□ □ Glasses / Contacts
□ □ Redness / itching / tearing
□ □ Floaters / spots
□ □ cataracts / Glaucoma / Macular degeneration
□ □ Poor vision (near or Far)
□ □ Blurred vision / Poor night vision

Ears
Past Current
□ □ Infections – recurring?
□ □ Ringing (High pitched or Low pitched)
□ □ Decreased Hearing

Skin & Hair
Past Current
□ □ Rashes / Hives
□ □ Acne / Pimples
□ □ Dry skin / oily skin
□ □ Bruise easily
□ □ Eczema
□ □ Psoriasis
□ □ Shingles / Herpes 1 or 2
□ □ Tumors, Lumps/ Cysts
(Location_____)
□ □ Hair loss (sudden?)

Nose, Throat & Mouth
Past Current
□ □ Nosebleeds
□ □ Sinus Infections
□ □ Hay Fever / Allergies
□ □ Gum / Teeth problems
□ □ Difficulty Swallowing
□ □ Frequent Sore throats
□ □ Dry Mouth or Throat
□ □ Hoarse voice

Respiratory
Past Current
□ □ Asthma / Bronchitis
□ □ Frequent Colds
□ □ COPD / Emphysema / Pneumonia
□ □ Chronic cough (dry or productive)
□ □ Coughing blood

Cardiovascular

Past Current

□ □ High / Low Blood Pressure
□ □ High cholesterol
□ □ Phlebitis / vein inflammation
□ □ Blood clots
□ □ Palpitations
□ □ Irregular Heart beat (non anxiety related)
□ □ Chest Pain / Pressure (rest or exertion)
□ □ Poor circulation
□ □ Swelling of hands / feet

Neurological

Past Current

□ □ Seizures
□ □ Tremors (Location_____)
□ □ Numbness or tingling of limbs
□ □ Pain
□ □ Paralysis

Gastro-intestinal

Past Current

Bowel Movements: Frequency_____

□ □ Diarrhea (chronic or alternating)
□ □ Constipation (chronic or alternating)
□ □ Frequent indigestion
□ □ Flatulence (gas) / Belching
□ □ Acid reflux / GERD
□ □ Nausea / Vomiting
□ □ Pain or cramps (location _____)
□ □ Blood in stools
□ □ Pale or black stools
□ □ Rectal pain / hemorrhoids
□ □ IBS / Chron's / Ulcerative colitis
□ □ Ulcers
□ □ Bad Breath

Genito- Urinary

Past Current

□ □ Frequent urination
□ □ Urgency
□ □ Unable to Hold / incontinence
□ □ Pain with urination
□ □ Blood in urine
□ □ Weak urine stream
□ □ Kidney Stones
□ □ UTI's

Male

Past Current

□ □ Impotence
□ □ Premature Ejaculation
□ □ Testicular lumps / masses
□ □ Benign Prostatic Hyperplasia
□ □ Genital itching / pain
□ □ Genital Lesions or discharge
□ □ Weak Urinary Stream
□ □ Decreased / Excessive Libido

Infection Screening (Positive Test)

Past Current

□ □ HIV / TB
□ □ Hepatitis
□ □ Gonorrhea / Syphillis
□ □ Genital Warts or HPV
□ □ Herpes – Oral or Genital

Female

Past Current

□ □ Irregular Periods
□ □ Painful Periods / cramps
□ □ PMS symptoms
(Breast tenderness / Lower Back pain/, irritability weepiness/ moodiness)
□ □ Urinary Tract Infections (UTI's)
□ □ Vaginal or Yeast Infections
□ □ Genital Pain or itching
□ □ Genital Lesions or discharge
□ □ Pelvic Inflammatory Disease (PID)
□ □ Abnormal bleeding / spotting
□ □ Breast Lumps / pain
□ □ Abnormal Pap Smear (date_____)
□ □ Decreased or Excessive Libido

Date of Last Period: _____

Typical duration: _____

Change in BM's before?

Color? Clots ?

Pregnancies

Total Pregnancies_____Living_____
Ectopic _____ # Miscarriages_____
Abortions_____

Age of onset of Menses _____
Age of onset of Menopause _____

□ □ Menopausal Syndrome
- Date of Last Period:
- Hormone replacement Therapy:

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 will notify Anita Lang-Bakar, L.Ac if I change any of my Medications or start taking new ones.

• 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.

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
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.

I understand that if I use insurance, **I will be charged 6$** by Driftwood Acupuncture to file each claim.
Initial _____

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 notice 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.)