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

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

- ☐ Tobacco _____
- ☐ Coffee drinking, ___cups/day
- ☐ Alcohol drinking, ___drinks per day/wk/mo
- ☐ Recreational drugs
- ☐ Special Diet:_____
- ☐ Exercise:_____
- ☐ Relaxation/Meditation

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	☐	☐		
Father	☐	☐		
Sibling	☐	☐	F M	
Sibling	☐	☐	F M	
Sibling	☐	☐	F M	
Grandmother	☐	☐	Maternal	
Grandfather	☐	☐	Maternal	
Grandmother	☐	☐	Paternal	
Grandfather	☐	☐	Paternal	
Other:	☐	☐		
Other:	☐	☐		

OFFICE POLICY:

All fees for medical services are due at the time services are rendered.

As a service to you and upon request, this office will complete your claim forms and bill your insurance company. Know that your insurance plan is a contract between you and your insurance company and is not a substitute for payment. Therefore, you are responsible for all charges that are not paid by your insurance company. Even with verification of benefits, we cannot guarantee what your plan covers, if anything. We will do our best in the preparation of insurance claims for services provided. There may be an insurance billing fee charged of 8.5% should you choose to have this office process your claims. This will only be charged if the insurance reimbursment does not fully cover the cost.

I authorize the release of medical or other information necessary for insurance purposes.

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.

For any change or cancellation of an appointment, a minimum 24 hour notice is required to avoid a late fee for the full amount for the appointment.

➔ **Signature:** _____ **Date:**_____
(Patient, Parent, Guardian)

For Clinic purposes only:
Witness to Patient's signature: _____ Date: _____
(Staff member)