Ito Acupuncture

1211 N. Main Street
Los Angeles, CA 90012

PATIENT INFORMATION AND HEALTH HISTORY

General Information (Please print)

NAME _____ DATE _____

ADDRESS _____

CITY _____ ZIP _____

PHONE _____ E-MAIL ADDRESS _____

BIRTH DATE _____ AGE _____ GENDER ***M*** / ***F***

MARITAL STATUS Single / Married / Separated / Divorced / Widowed (circle one)

LANGUAGE PREFERENCE _____ Do you require interpretive services? ***Y*** / ***N***

How did you hear about us? Yelp / Google / Facebook / Other _____

Who referred you to acupuncture? _____

Cancellation Policy

All scheduled appointments require at least 24 hours notice of cancellation. Appointments not cancelled within 24 hours may be subject to a $50.00 charge.

Initials of Participant or Guardian: _____

Credit Card information

CARD NUMBER _____ TYPE **MC** / **VISA** / **AMEX** / **OTHER**

EXPIRATION DATE _____ / _____ SECURITY CODE _____

NAME ON CARD _____

SIGNATURE _____

Emergency Information

CONTACT NAME _____ RELATIONSHIP_____

CONTACT'S PHONE NUMBER _____

PRIMARY CARE PROVIDER'S NAME _____

CITY _____ PHONE NUMBER (if known) _____

Reviewed by: David Ito, L.Ac: _____

PATIENT NAME _____ **DATE** _____

MEDICAL HISTORY QUESTIONNAIRE

Appointment Information

What is your main reason for making this appointment? _____

_____

When was your last medical exam or check up? _____

	Yes	***No***	*If yes, please explain any answer:*
Have you had acupuncture before?	☐	☐	When? _____ Reason: _____
Do you have the tendency to faint?	☐	☐	_____
Do you have a pacemaker?	☐	☐	When was the surgery? _____
Do you have Hepatitis A, B, C, D, E?	☐	☐	If yes, which one? A / B / D / E How long? _____
Are you HIV+?	☐	☐	If yes, how long?_____
Do you smoke?	☐	☐	How long?_____ How many per day?_____
Do you use any recreational drugs?	☐	☐	If yes, which ones? _____
Do you drink alcohol?	☐	☐	How often?_____
Any major accidents, physical traumas or surgeries?	☐	☐	_____ _____
Do you have any skin allergies?	☐	☐	_____ _____
Do you believe you are pregnant?	☐	☐	How many months? _____

Family Medical History

Please indicate if any of your blood relatives **now have** or **have had** any of these conditions?

☐ Heart disease	☐ High/low blood pressure	☐ Emotional disorders	☐ Fainting
☐ Irregular heart rhythm	☐ High Cholesterol	☐ Paralysis	☐ Tuberculosis
☐ Chest pain/discomfort	☐ Heart murmurs	☐ Cancer	☐ Obesity
☐ Respiratory disorders	☐ Dizziness/vertigo	☐ Stroke	☐ Diabetes
☐ Excessive Fatigue	☐ Bleeding disorders	☐ Epilepsy	☐ Anemia

Physical Activity History

Please indicate the type and amount of exercise or activity that you do regularly. (What, how long, how often)

Dietary Habits

Please describe how you typically eat. (What, when, how often, food allergies, cravings)

Reviewed by: David Ito, L.Ac: _____

PATIENT NAME _____ **DATE** _____

GENERAL MEDICAL HISTORY

Please indicate if you have now or have any of these conditions by marking with a "C" for current and a "P" for past.

Head and Neck
__ Dizziness
__ Fainting
__ Enlarged Lymph glands
__ Headaches
Other _____

Ears
__ Infection
__ Ringing
__ Loss of hearing
__ Pain
Other _____

Eyes
__ Blurred vision
__ Changes in vision
__ Poor night vision
__ Spots or floaters
__ Inflammation/stys
Other _____

Nose/throat/mouth
__ Bleeding
__ Sinus infections
__ Allergies
__ Sore throat
__ Hoarseness
__ Changes in taste
__ Difficulty swallowing
__ Changes in smell
__ Ulcers/Canker sores
__ Sore/bleeding gums
__ Toothaches
__ Teeth problems
Other _____

Skin
__ Hives
__ Rashes
__ Allergies
__ Eczema
__ Psoriasis
__ Night sweat
__ Excess sweating
__ Dryness
__ Bruise easily
Other _____

General
__ Fatigue
__ Thirst
__ Changes in appetite
__ Poor appetite
__ Aversion to cold
__ Aversion to wind
__ Frequent dreams/nightmares
__ Depression
__ Agitation
__ Irritability
__ Anxiety
__ History of psychiatric treatment
__ Poor memory
__ Difficulty concentrating
__ Sores that don't heal
__ Surgical implants
__ Unusual bleeding or discharges
__ Jaundice
__ Epstein Barr (EBV) or Mononucleosis (Mono)
__ Rheumatic fever
__ Thyroid disorder
__ Cancer
__ Anemia
__ Lupus
Other _____

Neurological
__ Numbness
__ Tingling
__ Allergies
__ Seizures
__ Tremors
__ Paralysis
__ Epilepsy/convulsions
Other _____

Infection History
__ Staph
__ MRSA
__ Gonorrhea
__ Chlamydia
__ Syphilis
__ Genital warts
__ Herpes
__ TB
Other _____

Gastrointestinal
__ Indigestion
__ Nausea
__ Bloating
__ Stomach pain
__ IBS
__ Colitis
__ Crohn's disease
__ Pancreatitis
__ Bowel movement changes
__ Frequent diarrhea
__ Frequent constipation
__ Dry hard stools
__ Soft sticky stools
__ Loose stools
__ Bloody stools
__ Excessive hunger
__ Hemorrhoids
__ Vomiting blood
__ Peptic ulcer
__ Recent changes in weight
__ Food cravings
Other _____

Cardiovascular
__ Palpitations
__ Chest pain or tightness
__ Rapid heartbeat
__ Heart disease
__ Poor circulation
__ Swollen ankles
__ Phlebitis
__ Cold hands/feet
__ Pacemaker
__ Hoarseness
__ High blood pressure
__ Stroke
Other _____

Respiratory
__ Chronic cough
__ Coughing up blood
__ Coughing up phlegm
__ Difficulty breathing
__ Wheezing/asthma
__ Frequent colds
__ Emphysema
__ Pneumonia
__ COPD
Other _____

Women
__ Frequent vaginal infections
__ Infertility
__ Pain/itching of genitals
__ Genital lesions/discharge
__ Pelvic inflammatory disease
__ Abnormal pap smear
__ Irregular periods
__ Emotional changes with menses
__ Clots in menses
__ Painful menstrual cramps
__ PMS
__ PCOS
__ Abnormal bleeding
__ Menopausal symptoms
__ Breast lumps/cysts
__ Breast swelling/pain
Other _____
When was your last period?
_____
How many days between periods? _____
Color? _____
Clots? _____

Men
__ Pain/itching of genitals
__ Genital lesions/discharge
__ Impotence
__ Premature ejaculation
__ Prostate problems
__ Infertility
Other _____

Urinary
__ Frequent urination
__ Frequent UTI
__ Weak stream
__ Changes in bladder habits
__ Kidney disease
How many times do you urinate per day ? _____
How many times do you urinate at night ? _____
Other _____

Please explain any situation above:

Do you have any other condition not listed above? ***Yes / No*** If yes, please state:

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PATIENT NAME _____ **DATE** _____

MUSCULOSKELETAL MEDICAL HISTORY

Please indicate if you have any of these conditions by marking with a "C" for current and a "P" for past.

General
__ Chest pain/discomfort
__ Chest Pain with cough
__ Pain when coughing
__ Pain in the ribs
__ Epigastric Pain
__ Lower abdominal Pain

Shoulder
__ Pain L/R (circle one)
__ Pain with movement
__ Pain with overhead movement
__ Loss of movement
__ Shoulder "gives out"
__ Swelling
__ Frozen shoulder
__ Dislocation
__ Tendonitis
__ Bursitis
__ Rotator cuff
Other _____

Hands/Wrist
__ Cold/Hot hands
__ Numbness/Tingling
__ Loss of grip strength
__ Pain with movement
__ Swelling
__ Carpal tunnel
__ Arthritis
Other _____

Abdomen
__ Hernia
__ Tenderness
__ Belly button pain when coughing or sneezing

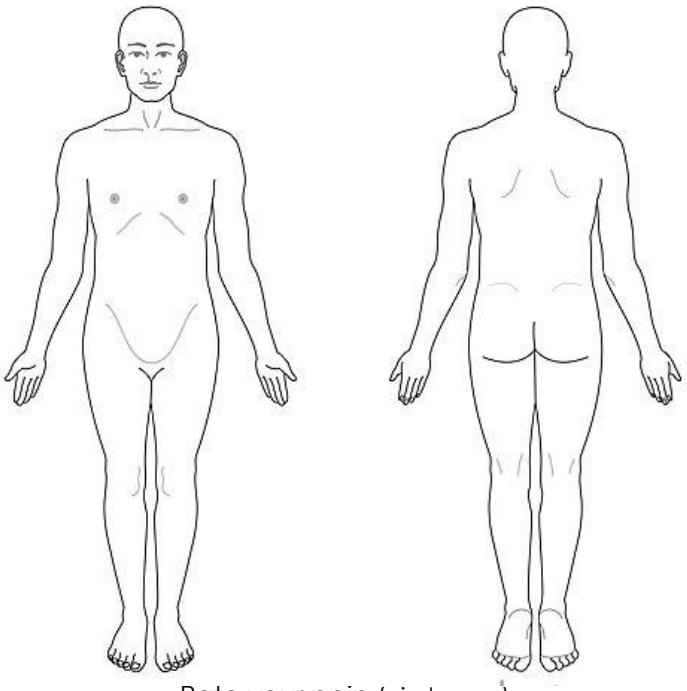
Upper/Mid Back
__ Pain when lifting
__ Pain while standing
__ Pain while twisting
__ Pain as you stand up
__ Disk problems
__ Degenerative disc
__ Herniated
__ Stenosis
__ Scoliosis
__ Spinal fusion
Other _____

Knee
__ Pain L / R (circle one)
__ Swelling or redness
__ Pain with movement
__ Loss of flexibility
__ Pain bearing weight
__ Pain going down stairs
__ Pain going up stairs
__ Pain or stiffness after sitting for long periods
__ Stiff when getting out of bed
__ Knee gives out or locks
__ Grinding noise or feeling
__ Stiff when getting out of bed
__ Knee Replacement ***L / R***
__ Meniscus
__ ACL / PCL / MCL
__ Tendonitis
__ Bursitis
Other _____

Arms/Forearms/Elbow
__ Cold/Hot hands
__ Numbness/Tingling
__ Loss of strength
__ Loss of movement
__ Pain with movement
__ Tennis or golfer's elbow
__ Psoriasis
__ Arthritis
__ Fractures or breaks
__ Dislocation
Other _____

Low Back
__ Sudden pain
__ Pain comes on when constipated
__ Pain as you defecate
__ Pain radiates to groin
__ Pain worse in morning
__ Stiff when getting out of bed
__ Unable to twist/turn at waist
__ Degenerative disc
__ Pinched nerves
__ Stenosis
__ Sciatica
__ Herniated
__ Spinal fusion
Other _____

Please mark with an "X" where you **currently** have pain.



Rate your pain (circle one)
(Mild) ***1 2 3 4 5 6 7 8 9 10*** (Severe)

Quality of pain (circle one)
Dull Achy Sharp Burning Stabbing Numb

Radiating Tingling Cramping Other

Neck
__ Pain with movement
__ Pain with tilting / twisting
__ Whiplash
__ Loss of flexibility
__ Worse getting out of bed
__ Stiff neck
__ Grinding/popping noise
__ Degenerative disc
__ Pinched nerves
__ Stenosis
__ Herniated
__ TMJ
__ Spinal fusion
Other _____

Hips/Pelvis/Legs
__ Hernia
__ Fractures/breaks/dislocation
__ Hip Replacement
__ Groin pain with coughing
__ Stiff when getting out of bed
Other _____

Feet/Ankles
__ Psoriasis
__ Numbness/Tingling
__ Sprained ankle
__ Arthritis
__ Achilles tendonitis
__ Fractures or breaks
Other _____

Please further explain any situation stated above:

Do you have any other condition not listed above? *Please explain:*

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PATIENT NAME _____ **DATE** _____

MEDICATIONS

Please list all medications, herbal supplements, nutritional supplements, or vitamins and minerals that you take regularly as well as the reason why you are taking them.

Date:	Medication:	Reason:	Dose and How often:		Date of last dose:	Prescribed by:	Start date:

Reviewed by: David Ito, L.Ac: _____

PATIENT NAME _____ **DATE** _____

Informed Consent

I hereby request and consent to the performance of acupuncture treatments and any other procedures within the scope of the practice of acupuncture on me (or on the patient name below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturist who now or in the future may treat me while associated with or serving as back up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that treatment methods may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, *tuina* (Chinese massage), ear acupuncture, Chinese medicine, herbal medicine, corrective exercises and methods and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising numbness or tingling near the near the site that may last for a few days, and dizziness or fainting. Burning and/or scaring are a potential risk of moxibustion and cupping or when the treatment involves the use of heat lamps. Bruising is a common side effect of cupping. The usual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax) to name just a few. Infection is another possible risk, although the clinic uses sterile disposable needles, seeds and instruments and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I also understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives, and tingling of the tongue in addition to many others. I will notify the clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complaints complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff things at the time, based upon the facts then known, is in my best interest. I understand the results are not guaranteed.

I understand that the clinical staff may review my patient records and lab reports, but all my records and lab reports will be kept confidential and will not be released without my written consent. With my consent, Acupuncture Pain and Performance or any of its agents may email, text or call me with appointment reminders and patient statements. I understand that I have the right to request that Acupuncture Pain and Performance or any of its agents restrict how it uses or discloses my personal health information to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing below, I authorize the release of medical information necessary to process any insurance claim.

In addition to being treated at Ito Acupuncture Pain and Performance, I may also understand that I may be treated in the public space. Although, I will be receiving treatment in a public place, I understand that the acupuncturist will take all reasonable measures under the circumstances to maintain my privacy. However, I acknowledge and accept that your privacy cannot be guaranteed.

ASSIGNMENT OF BENEFITS (If you have insurance other than Blue Cross) With the signature below, I give permission for my insurance company to assign benefits and send payment directly to David Ito, L.Ac, at 430 E. Avendia De Los Arboles #105, Thousand Oaks, CA 91360 for acupuncture services that have been provided to me.

FINANCIAL AGREEMENT ASSIGNMENT OF BENEFITS I am receiving or about to receive healthcare services in this office. I understand that I am responsible to pay all non-insurance related fees when services are rendered, including herbs, etc. If I choose to use my insurance, I understand that I will be responsible for all "non-covered" services and/or coinsurance/co-pays associated with my office visit. In addition, I also authorize insurance payments of medical benefits to Acupuncture Pain and Performance and/or David Ito.

USE IMAGE My photographic/video images, and/or testimonial may be used for: Social media and/or advertising. I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Ito Acupuncture Pain and Performance. I understand that the information disclosed pursuant to this authorization may be subject to disclosure and may no longer be protected by HIPPA privacy regulations. I understand that this authorization may be revoked at any time, but such revocation must be in writing and received by the practice via registered mail. Any revocation affects disclosures moving forward and is not retroactive. This authorization expires 99 years from signing date.
To decline initial: _____

By voluntarily signing below, I show that I have read, or have had read to me the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and I've had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

_____ _____

Date **Signature of Patient or Personal Representative**

_____

Print Name

Description of Person Representative's Authority:

_____

Reviewed by: David Ito,