Eastern Body Therapy

2310 6th Avenue San Diego, CA 92101 (619)772-4002

Personal Information

Name_____ Date of injury/illness_____

Address:_____ Apt._____ City_____ State_____ Zip_____

Home phone: ( )_____ Work Phone: ( )_____ E-mail:_____

Social Security #:_____ Date of Birth:_____ Drivers License#_____

Employer/school_____ Full time____ Part time ____ Occupation:_____

Spouse's name:_____ Work phone: ( )_____

Referred By_____Preferred Language:_____

Have you had acupuncture before? _____yes _____no

Is your condition a result of a work injury? ___yes ___no Automobile accident ___yes ___no

Responsible Party Information

Responsible party:_____ Date of birth: _____

Relationship to patient: _____self _____spouse _____other _____ SS#:_____

Responsible party's home phone: ( )_____ Work phone: ( )_____

Address:_____ Apt._____ City_____ State_____ Zip_____

Employer's name:_____ Phone number: ( )_____

Occupation:_____

If patient is a child, other parent's name:_____

Home address: _____ Apt._____ City_____ State_____ Zip:_____

Home phone: ( )_____ Work phone: ( )_____ Occupation:_____

Patient's Insurance Information

PRIMARY insurance company name:_____

Insurance address: _____City:_____ State:_____ Zip:_____

Name of insured: _____Date of birth:_____

Relationship to patient: ____self ____spouse ____parent ____other _____

Insurance ID #:_____ Group #:_____

SECONDARY insurance company name:_____

Insurance address: _____City:_____ State:_____ Zip:_____

Name of insured:_____ Date of birth:_____

Relationship to patient: ____self ____spouse ____parent ____other _____

Insurance ID #:_____ Group #:_____

Emergency Contact

Name:_____ Relationship:_____

Address: :_____Apt._____ City_____ State_____ Zip_____

Home phone: ( )_____ Work Phone: ( )_____

ASSIGNMENT OF BENEFITS – FINANCIAL AGREEMENT

Assignment and release: I authorize payment of benefits be made directly to the healthcare provider. I understand that I am responsible for any and all charges not paid by my insurance. I authorize the release of any information required by my insurance companies to process this claim, including medical records and dates of service.

Signed:_____ Date:_____

History of current complaint

Reason for today's visit_____

_____

How long have you had these symptoms?_____

What other treatment have you had for this condition?_____

_____

_____

What seems to make it better?_____

What seems to make it worse?_____

Please list other conditions for which you are under the care of a physician:_____

_____

What medications are you taking? (Please include over the counter medications, herbs, and vitamins as well as prescription medications)_____

_____

_____

Do you know what your blood pressure usually is? _____yes _____no if yes: _____/_____

Lifestyle Information

Appetite ____low ____high ____moderate

Are you vegetarian? ____yes ____no

Do you have cravings for specific foods? ____yes ____no

If yes, what do you crave? _____

How many glasses of water do you drink in a typical day? _____

Regular Exercise Type_____ How often_____

Medical History

Please check any of the following conditions you currently have or have previously had:

Now	Previous		Now	Previous		Now	Previous	
___	___	Alcoholism	___	___	Diabetes	___	___	Pacemaker
___	___	Allergies	___	___	Epilepsy	___	___	Pneumonia
to what _____			___	___	Fibromyalgia	___	___	Polio
_____			___	___	Gout	___	___	Rheumatic Fever
___	___	Anemia	___	___	Heart Disease	___	___	Scarlet Fever
___	___	Appendicitis	___	___	Hepatitis	___	___	Seizures
___	___	Arteriosclerosis	___	___	Herpes	___	___	Stroke
___	___	Asthma	___	___	High Blood Pressure	___	___	Thyroid Disorders
___	___	Cancer	___	___	HIV/AIDS	___	___	Tuberculosis
type_____			___	___	History of Abuse	___	___	Ulcers
_____			___	___	Measles	___	___	Venereal Disease
___	___	Chicken Pox	___	___	Mental Illness	___	___	Other (Please
___	___	Chronic Fatigue	___	___	Multiple Sclerosis	explain)_____		
___	___	Depression	___	___	Mumps	_____		

Please list dates and types of all surgeries you have had: _____

_____

_____

Please list any major traumas and accidents you have had: _____

_____

_____

Family Medical History

Please check any of the following that someone in your immediate family (sisters, brothers, parents, grandparents, aunts, uncles) has had

Condition	Who has it?	Condition	Who has it?
Allergies	_____	Diabetes	_____
Asthma	_____	Heart Disease	_____
Alcoholism	_____	High Blood Pressure	_____
Cancer	_____	Seizures	_____

General Symptoms

- ❑ Poor appetite
- ❑ Heavy appetite
- ❑ Prefer cold drinks
- ❑ Prefer hot drinks
- ❑ Recent weight gain/loss
- ❑ Poor sleep
- ❑ Heavy sleep
- ❑ Dream disturbed sleep
- ❑ Fatigue
- ❑ Lack of strength
- ❑ Bodily heaviness
- ❑ Cold hands or feet
- ❑ Poor circulation
- ❑ Shortness of breath
- ❑ Fever
- ❑ Chills
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Muscle cramps
- ❑ Vertigo or dizziness
- ❑ Bleed or bruise easily
- ❑ Peculiar taste in mouth

Head, Eyes, Ears, Nose, Throat

- ❑ Glasses
- ❑ Eye strain
- ❑ Eye pain
- ❑ Red eyes
- ❑ Itchy eyes
- ❑ Spots in eyes
- ❑ Poor vision
- ❑ Blurred vision
- ❑ Night blindness
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Teeth problems
- ❑ Grinding teeth
- ❑ TMJ
- ❑ Facial pain
- ❑ Gum problems
- ❑ Sores on lips or tongue
- ❑ Dry mouth
- ❑ Excessive saliva
- ❑ Sinus problems
- ❑ Excessive phlegm
- ❑ Recurrent sore throat
- ❑ Swollen glands
- ❑ Lumps in throat
- ❑ Enlarged thyroid
- ❑ Nose bleeds
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Earaches
- ❑ Headaches
- ❑ Migraines
- ❑ Concussions
- ❑ Other:_____ _____ _____ _____

Respiratory

- ❑ Difficulty breathing when lying down
- ❑ Shortness of breath
- ❑ Tight chest
- ❑ Asthma
- ❑ Wheezing
- ❑ Wet cough
- ❑ Dry cough
- ❑ Coughing blood

Cardiovascular

- ❑ High blood pressure
- ❑ Blood clots
- ❑ Low blood pressure
- ❑ Fainting
- ❑ Chest pain
- ❑ Difficulty breathing
- ❑ Rapid heart beat
- ❑ Heart palpitations
- ❑ Phlebitis
- ❑ Irregular heart beat
- ❑ Other_____ _____ _____

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting
- ❑ Acid regurgitation
- ❑ Gas
- ❑ Hiccup
- ❑ Bloating
- ❑ Bad breath
- ❑ Diarrhea
- ❑ Constipation
- ❑ Laxative use

- ❑ Black stools
- ❑ White, chalky stools
- ❑ Bloody stools
- ❑ Mucous in stools
- ❑ Intestinal pain or cramping
- ❑ Itchy anus
- ❑ Burning anus
- ❑ Rectal pain
- ❑ Hemorrhoid
- ❑ Anal fissures
- ❑ Other_____ _____ _____ _____

Musculoskeletal

- ❑ Neck/shoulder pain
- ❑ Muscle pain
- ❑ Upper back pain
- ❑ Low back pain
- ❑ Joint pain
- ❑ Rib pain
- ❑ Limited range of motion
- ❑ Muscle weakness
- ❑ Other_____ _____ _____ _____

Skin and Hair

- ❑ Rashes
- ❑ Hives
- ❑ Ulcerations
- ❑ Eczema
- ❑ Psoriasis
- ❑ Acne
- ❑ Dandruff
- ❑ Itching
- ❑ Hair loss
- ❑ Change in hair/skin texture
- ❑ Fungal infections
- ❑ Other_____ _____ _____ _____

Neuro/psychological

- ❑ Seizures
- ❑ Numbness
- ❑ Tics
- ❑ Poor memory
- ❑ Depression
- ❑ Anxiety
- ❑ Irritability
- ❑ Easily stressed
- ❑ Abuse survivor
- ❑ Considered/ attempted suicide
- ❑ Seeing a therapist
- ❑ Other_____ _____ _____

Genito-urinary

- ❑ Pain on urination
- ❑ Frequent urination
- ❑ Urgent urination
- ❑ Blood in urine
- ❑ Unable to hold urine
- ❑ Incomplete urination
- ❑ Venereal disease
- ❑ Bedwetting
- ❑ Wake to urinate
- ❑ Increased libido
- ❑ Decreased libido
- ❑ Kidney stones
- ❑ Impotence
- ❑ Premature ejaculation
- ❑ Nocturnal emission
- ❑ Other_____ _____ _____

Gynecology

- ❑ Age menses began_____

- ❑ Number of days in cycle_____
- ❑ Duration of flow_____
- ❑ Irregular periods
- ❑ Painful periods
- ❑ Heavy flow
- ❑ Light flow
- ❑ Clotted flow
- ❑ PMS
- ❑ Vaginal discharge (color_____ _____)
- ❑ Vaginal sores
- ❑ Vaginal odor
- ❑ Breast tenderness
- ❑ Breast lumps
- ❑ Pregnancies #_____
- ❑ Live births #_____
- ❑ Premature births #_____
- ❑ Age at menopause _____
- ❑ Date of last PAP _____
- ❑ Date last period began _____

Is there anything else you feel we should know about you?_____

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to help us to help you!