ACU-CARE HEALTH CENTERS
Acupuncture Herbal Pharmacy Holistic Health Care

Kimberly Hoover, L.Ac., Dipl. N.C.C.A.
M.A. Traditional Oriental Medicine

2852 Adams Ave.
San Diego, CA 92116
(619) 282-8068

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4514 Bonita Rd.
Bonita, CA 91902
(619) 470-4714

PATIENT INTAKE FORM

Today's Date:__________________ Date of Birth:________________Age:______

Name:________________________________S.S.#:________-_________-________

Home Address:____Apt.:_________

City: ___________________________ State:_____________Zip:_______________

Home Phone:_(_____)_________________ E-mail:__________________________

Work Phone:_(_____)__________________ Cell/Pager:_(_____)_______________

Marital Status: M S D W (check one only) Number of Children:_________

Could we thank someone for referring you to our office?__________________________

In case of emergency, contact____

Are you employed? Yes No (check one only) If so, what is your occupation___________________

INSURANCE INFORMATION

Do you have health insurance? Yes No (check one only)

Name of Insurance Company____

What type of policy is it? Individual Group (check one only)

Are you insured through you spouse's insurance policy? Yes No (check one only)

If so, what is the name of the company?____________________________________

CURRENT MEDICAL HISTORY

List which health problems you are seeking treatment for in order of importance to you:
(i.e. #1 being most painful or problematic, #4 being least painful or problematic)

I.______________________________ 3.______________________________

2.______________________________ 4.______________________________

List any medications, supplements and/or herbs you are currently taking and why:

I.______________________________ 4.______________________________

2.______________________________ 5.______________________________

3.______________________________ 6.______________________________

List any allergies:____

Do you have a pacemaker? Yes No

Are you currently pregnant? Yes No

Do you have any of the following:

1. A change in bowel or bladder habits
2. A sore that doesn't heal
3. Any unusual bleeding or discharge
4. Thickening or lump in breast or elsewhere
5. Indigestion or difficulty swallowing
6. Obvious change in a wart or mole
7. Nagging cough or hoarseness

PAST MEDICAL HISTORY

List any accidents, surgeries or hospitalizations, including approximate dates:

1.______________________________ 3.______________________________

2.______________________________ 4.______________________________

Indicate any significant illness **you** have now or have had previously:

Cancer____Diabetes____Hepatitis____Heart Disease____Emotional Disorders____HIV____

Please indicate the use and frequency of the following substances:

Tobacco/Marijuana:________________ Coffee/Black Tea:________________

Alcohol:__________________________ Drugs:__________________________

CURRENT HEALTH STATUS

A. Your current stress level is:

Low Medium High

B. Any recent use of antibiotics?

Yes No

C. Your current weight is_______lbs.

D. Your current height is_____ft._____inches

E. Your last cholesterol level:______

F. Your last blood pressure reading: ___/___

GENERAL HEALTH QUESTIONNAIRE (please circle answers)

BODY TEMPERATURE

1. In general, your body temperature is:

cold all over cold hands & feet normal hot

2. Are you currently having any of the following:

low grade fever fever chills none

PERSPIRATION

1. Do you:

sweat too easily sweat on exertion only cannot sweat night sweat

HEADACHES/DIZZINESS

1. Do you have headaches: yes no

2. If you do, how often do you have them:

daily weekly monthly rarely

3. Where is the pain:

frontal/sinus temples side of head back of head top of head

4. Do you have dizziness? yes no

PAIN

1. Are you currently having pain? yes no
2. If you are having pain is it best described as:
   dull/achy sharp/stabbing heavy sensation moves around
3. The pain is better with: heat cold no change
4. Touch or pressure makes the pain: better worse no change
5. After eating the pain is: better worse no change
6. The type of weather that makes it worse is: hot damp cold no change
7. On a scale of 1-10, your pain is usually: (i.e. 1 is mild; 10 is the worst you can imagine)

   0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

APPETITE/THIRST

1. How many times per day do you eat including snacks?
   1 2 3 4 5
2. Your appetite is: low medium excessive
3. The amount of thirst you experience is: low medium excessive
4. You like your drinks to be: hot room temp. cold

SLEEP

1. Do you wake up feeling rested? yes no
2. How many hours do you usually sleep? 5-6 7-8 9-10
3. Do you have difficulty sleeping? yes no
4. Do you have trouble with:
   falling asleep staying asleep nightmares

EMOTIONAL/MENTAL

1. Do you experience any of the following frequently?
   depression irritability worry fear anxiety anger

URINATION

1. Usually, how many times do you urinate each day? 1-2 2-3 4-5 5+
2. Usually, how many times do you urinate each night? 0 1 2 3+
3. Is there any pain or discomfort on urination? yes no

ELIMINATION

1. Usually, how many times do you move your bowels each day? 0 1 2 2+
2. The consistency of the stool is?
   diarrhea loose formed over dry

WOMEN ONLY

1. Do you have a menstrual cycle? not yet yes no
2. Are you using birth control? yes no What type?________________
3. Is your cycle regular? yes no
4. How many days does your period last? 2-3 4-5 6-7 7+
5. Do you have any problems related to your cycle?
   PMS Cramps Breast tenderness spotting between yeast infections
6. Do you have any sexually transmitted disease, if so which one?
   herpes genital warts chlamydia other
7. When was you last gynecological exam?____________Results:______________

MEN ONLY

1. Are you having any problems with sexual dysfunction? yes no
2. Do you have any pain or testicular masses? yes no
3. Have you had a P.S.A. test? yes no Results?_________________

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Acupuncture * Herbal Pharmacy * Facial Rejuvenation
Kimberly Hoover, L.Ac., M.T.O.M., D.N.C.C.A., D.N.B.A.O.
Licensed Acupuncturist, Board Certified in Orthopedics

Cancellation Policy

We strive to give each one of our patients the very best service possible. We value your patronage and look forward to a long and rewarding relationship.

It is in this spirit that we would like to inform you of our policy concerning missed appointments.

To discourage no-shows and same day cancellations, we must require that 24 hours notice be given to cancel or reschedule appointments. If 24 hours notice is not given there will be a fee of $25.00.

We regret the need for this policy and sincerely hope you will not be affected by it.

Patient Signature:________________________________Date:_______________

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Dear Patient,

Some of you have been with me for many years now, and some of you are just new to this office. If you have been a patient for awhile, you know how much I value a friendly, trusting and caring atmosphere. This continues to be important to me. However, there have been recent changes in insurance practices which much to my dismay are affecting my practice.

It is quickly becoming standard procedure for insurance companies in California to require medical practices to use arbitration agreements. This is a legal agreement which relates to medical malpractice. In simplest terms, it states that should such a dispute occur, you are giving up your right to have that dispute decided in court, but you are agreeing to an arbitration instead.

You will be required to sign an arbitration agreement when you come in for your first visit for compliance with my insurance carrier.

Most respectfully yours,

Kimberly Hoover, L.Ac.
Licensed Acupuncturist