Karen Chan Acupuncture & Herbal Medicine

4220 H Street, Sacramento, CA 95819 916-891-2939

187 40th St. Way, Oakland, CA 94611 510-384-9226

www.KarenChanAcupuncture.com

Date: _____

Name: _____ Date of Birth _____ Gender: ____ Age:_____

Address: _____City: _____ State: _____ Zip: _____

Birth Place: _____ Number of children: _____

Email: _____

Occupation: _____ Employer: _____

Cell: _____ Work: _____ Home: _____

Marital Status: _____ Spouse's Name: _____ Phone #: _____

Emergency contact & relationship: _____ Phone #: _____

How did you hear about Karen Chan Acupuncture? _____

Who referred you so we can thank your referral? _____

Cancellation Policy

- Appointment cancellations must be made at least 24 hours in advance to avoid a $55 cancellation fee.
- "No Show" and cancellations on the day of your appointment are billed the entire charge of $95 as I am unable to fill that time.
- **Cancellation policy for the Oakland location is 48 hours in advance to avoid a $95 cancellation fee as I am unable to fill that time that is reserved just for you.
- Your credit card will be stored in the billing App to charge for cancellation or no show appointments.
- By signing below, you are giving consent to charge your card due to last minute cancellation or no show. Please fill out your credit card info below. Once it is stored in the billing app, this portion of form with your credit card info will be shredded for your security.

Patient Signature: _____ Print Name: _____ Date: _____

Name on card: _____ CVV Code: _____

Credit Card number: _____ Zip code: _____

Visa MC Amex Discover FSA HSA

Main Complaint(s), in order of importance to you and date of onset:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Have you been treated for this condition before? Yes _____ No _____

If so, when and what means of treatment? _____

_____

_____

List any surgery you have had and the date:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

List any medications, OTC prescriptions, herbs you are taking.

1. _____
2. _____
3. _____

Additional Information you like to add.

_____

_____

_____

Is there a family history of:
__ Cancer __ TB __Diabetes __ Arthritis __High blood pressure __ Mental illness __ Asthma
__ Allergies __Other, please list: _____

Please check all that apply to you:
__ Allergies __ Anemia __ High blood pressure __ Heart trouble __Hepatitis __ HIV/AIDS
__ COVID (if so) Number of times had COVID? _____ Dates: _____
Other, please list: _____

Musculoskeletal

__ Muscle pain	_ Neck pain/stiff neck	_ Loss of grip
__ Muscle cramps/ spasm	_ Shoulder Pain	_ Hand or finger pain
_ Painful/swollen joints	_ Upper back pain	_ Wrist pain
_ Hip tightness	_ Mid back pain	_ Elbow pain
_ Cold pain	_ Lower back pain	_ Hand pain
_ Poor circulation	_ Hip pain	_ Ankle pain
_ Weak limbs	_ Sciatica Pain	_ Foot pain
_ Arthritis	_ Numbness/tingling in limbs	_ Hernia disc
_ Stiffness/Limited range of motion	_ Burning Sensation	_ Scoliosis
_ Bursitis	_ Swollen joints	

Male

__ Low or no sex drive	__ Painful testicles
__ Excess sexual desire	__ Seminal emission
__ Impotence	__ Weak urine stream
__ Infertility	__ Dribbling urination
__ Hernia	__ Urethra discharge
__ Prostate problem	

Female

Age started menstrual cycle _____	Length of cycle _____	___Lump in breasts/painful breast
Age stopped _____	Intervals between cycle _____	___ Ovarian cysts
Date of last cycle _____	Date last period began _____	___ Uterine cysts or tumors
Date of last PAP test _____	Quality of flow:	___ Excessive vaginal discharge
# of Pregnancies _____	___ Dark ___ Clots ___ Bright	___ Vaginal soreness
# of Caesareans _____	___ Excessive ___ Irregular cycle	___ Vaginal itch
# of Miscarriage _____	___ Light scanty bleeding	___ Vaginal odor
# of Abortion _____	___ Missed period	Vaginal discharge color: _____
Age at menopause _____	___ Cramps	_____
__ Hot Flashes	___ Low backache	Other: _____
__ Vaginal dryness	___ Mood changes	_____
	___ Water retention	

General

Weight _____	Occupational Hazards: _____
Height _____	Use sleeping pills Yes No __ Quantity/night
Blood Pressure _____	__ Work with chemicals
Appetite: Low Moderate High	__ Work involves sitting a lot
Thirst for water: Yes No __ Glasses/Day	__ Physical work
Coffee: Yes No __ Cups/Day	__ Driving a lot
Soda: Yes No __ Cans/Day	__ Exercise regular
Artificial Sweeteners: Yes No	__ Get enough sleep
Alcohol: Yes No __ Glasses/Day	__ Eat Regular meals
Smoking: Yes No __ Cigarettes/Day	Stress level: Mild Moderate High Extreme
Marijuana: Yes No __ Times/Day	Temperature: Often feel cold/Often feel hot/Comfortable
Other Drugs: _____	Prefers cold drinks Prefers hot drinks

Patient Name _____ Date _____

Please mark X for present condition and P for past condition

Liver / Gallbladder
__ Irritability
__ Anger / frustration
__ Argumentative / Aggressive
__ Depression
__ Headaches / migraines
__ Red eyes
__ Dry / Itchy eyes
__ Spots in front of eyes
__ Blurred vision
__ Night blindness
__ Sensitive to sunlight
__ Feeling of lump in throat
__ Clenching of teeth at night
__ Muscle cramping / twitching
__ Joints feel tight / stiff
__ Abdominal pain / rib pain
__ Mood swing
__ Easily stressed
__ Nervous
__ Cold hands / feet
__ Soft / brittle nails
__ Bitter taste in mouth (all day)
__ Difficulty making decision
__ Craving / avoiding sour foods

Kidney / Urinary Bladder
__ Frequent urination
__ Burning / painful urination
__ Incontinence
__ Incomplete urination
__ Genital discharge
__ Recurrent bladder infection
__ Weakness/Pain in lower back
__ Aching bones
__ Feel cold easily
__ Low sexual energy
__ Excess sexual desire
__ Short term memory
__ Loss of hair
__ Hearing problems
__ Ringing in ears
__ Ear aches, infection
__ Craving/avoiding salty food

Heart / Small Intestine
__ Heart palpitations
__ Chest pain
__ Dizziness
__ Insomnia
__ Poor memory
__ Easily startled
__ Easily sweat
__ Restlessness / agitation
__ Impulsive
__ Anxiety
__ Shortness of breath on exertion
__ Vivid dreams
__ Nightmares
__ Lack of joy in life
__ Laughing for no reason
__ Bitter taste in mouth(am)
__ Craving/ avoiding bitter foods

Lung / Large Intestine
__ Dry cough
__ Cough with sputum
__ Sinus problem
__ Poor sense of smell
__ Chronic cough
__ Dry mouth
__ Skin rashes
__ Itchy skin
__ Hives
__ worry
__ Grief, sadness
__ Shortness of Breath
__ Spontaneous sweating
__ Allergies
__ Sore throat
__ Hoarse voice
__ Frequent colds
__ Low physical stamina
__ Craving/avoiding spicy foods

Spleen / Stomach
__ Heaviness anywhere in body
__ Fatigue all the time
__ Hard to get up in the morning
__ Afternoon fatigue(after lunch)
__ Edema (swelling)
__ Muscles feel tired often
__ Easy bruising and bleeding
__ Acne
__ Bad Breath
__ Undigested food in stool
__ Low / excessive appetite
__ Frequently snacking
__ Tendency towards hypoglycemia
__ Difficulty digesting oily foods
__ Chemical sensitivities
__ Nausea
__ Vomiting
__ Gas / belching
__ Hiccup
__ Bloating
__ Hemorrhoids
__ Constipation / Diarrhea
__ Indigestion / heartburn
__ Ulcers
__ Abdominal pain
__ Over-thinking
__ Poor memory
__ Tendency to become obsessive
__ Bleeding or painful gum
__ Difficulty swallowing
__ Sticky stool
__ Mucous stool
Bowel Movements:
Frequency _____
Color _____
Odor _____
__ Craving / avoid sweets

Informed Consent For Acupuncture Treatment And Care

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed acupuncturist and/or other licensed acupuncturist who now or in the future treat me while employed, working or associated with or serving as a back-up for the treating acupuncturist named below, including those working at this office/clinic or any other office or clinic.

I understand that methods or treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese or Western herbal medicine, and nutritional counseling. Sometimes blisters can occur with moxibustion.

I understand sterile disposable needles will be used and may be placed in the external ear and/or body points.

I have had the opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain disease of dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, slight bleeding, temporary discomfort, infections, scarring and hematoma at site of needle. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

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. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastro-intestinal upset or allergic reactions to the herbs I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risk and complications, and I wish to reply on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above-named procedures. 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.

Patient's Signature: (parent if minor or guardian) _____ Date Signed: _____

Print Name: _____ Relationship to Patient: _____

ARE YOU PREGNANT? YES NO DO YOU HAVE A PACEMAKER? YES NO

Name of treating acupuncturist(s):_____Karen Chan, L.Ac._____