



621 Water Street
Santa Cruz, CA 95060
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Welcome to our office

Checks and cash are accepted for payment. Payment is due at the time of your visit. I will provide you with a “superbill” receipt that can be submitted to your insurance provider for reimbursement.

Confidential

Name: _____ Date of birth: _____ Age: _____

Address: _____

City,zip: _____

Phone:H _____ W _____ C _____

email address: _____

Occupation: _____

Contact in case of emergency: _____

How did you hear about me? _____

What is (are) the reason(s) for your visit today? _____

Cancellation Policy: Kindly give 24 hours notice of cancellation, at which time I can easily reschedule your appointment. You are expected to pay for the time set aside for you in case of a missed appointment, except for emergencies.

I have read and understand my responsibility for payment of services.

Signature _____ Date _____

Are you currently under the care of a Medical Doctor? _____ Date of last visit: _____

Name of MD: _____

Doctor's nurse: _____ Phone:(if you have it) _____

Are you currently seeing any other health care providers? If yes, please list the name and type of provider: _____

Have you ever been treated with Acupuncture or Chinese Medicine? _____

Please list the names of medications/vitamins/minerals/herbs you are currently taking: _____

Please list any allergies to food or medications:

Please list any surgeries you have had and the date: _____

Circle if you have experienced any of the following:

adverse reactions to medical treatment

allergies

asthma

anemia

arthritis

artificial heart valves or joints

bleeding disorder

blood disease

cancer or tumor

chemical dependency

diabetes

eating disorders

eye disorders

gout

headaches

kidney disorder

low blood pressure

musculo-skeletal disorder

organ transplant

pace maker

respiratory disorder

rheumatic fever

sciatica

seizures/epilepsy

sexually transmitted disease

skin problems

stomach or intestinal disorder

stroke

thyroid disorder

transfusion

heart disease

tuberculosis

hemophilia

ulcer

hepatitis, Jaundice, liver disorder

urinary tract infection

herpes 1,2

other _____

high blood pressure

immune disorder

Menses: circle all that apply: regular, irregular, clots, heavy flow, light flow, no periods, Pain, PMS, total or partial hysterectomy, menopause, breastfeeding, pregnant _____ weeks

How many days in your menstrual cycle? _____

How many days of bleeding in your menstrual cycle? _____

Have you used birth control pills? _____ How long? _____

When did you stop using them? _____

Do you use any other forms of contraception? _____

Have you been diagnosed with ovarian cysts, fibroids, or endometriosis? _____

(Please list the date you were diagnosed) _____

Fertility

List number of children and their ages _____

How long have you been trying to conceive? _____

How many times have you had IUI? _____ IVF? _____ ICSI? _____

Do you ovulate? _____ How do you check for for ovulation? _____

Pregnancies? _____ Miscarriage(s)? _____ at what week of pregnancy? _____

Have you had any abnormal laboratory tests related to gynecology or fertility?

Pain

If you have pain, list the areas affected: _____

What date did the pain begin? _____

Was there an injury or trauma that initiated the pain? _____

What is the severity of pain today?: 0 1 2 3 4 5 6 7 8 9 10

Gastrointestinal

Please describe any digestion problem: _____

Foods and beverages that worsen the condition: _____

Do you notice if the problem is worse on a full or empty stomach? _____

Describe your usual diet, including how many meals or snacks per day? _____

Please circle which applies:

constipation, loose stool, blood in stool, painful, grey color, urgency, foul smell,

Do you have a bowel movement daily? _____

Do you often wake to during the night to urinate? _____ How many times? _____

Is there any difficulty with urination? _____

Sleep

Do you sleep well? _____ Fall asleep easily? _____

Wake up often during the night? _____ How many hours of sleep do you get? _____

Describe your general mood _____

Do you exercise? _____ What type and how often? _____
