



621 Water Street  
Santa Cruz, CA 95060  
Office: 831-457-2848 Fax: 831-457-1407

*Welcome to our office*

**Check, cash, and credit 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  
hemophilia  
hepatitis, Jaundice, liver disorder  
herpes 1,2  
high blood pressure  
immune disorder

tuberculosis  
ulcer  
urinary tract infection  
other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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

Do you exercise? \_\_\_\_\_ What type and how often? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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 \_\_\_\_\_

---