

**PERSONAL INFORMATION**

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LAST NAME \_\_\_\_\_ HOME # \_\_\_\_\_  
FIRST NAME \_\_\_\_\_ WORK # \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CELL # \_\_\_\_\_  
CITY \_\_\_\_\_ SOCIAL SEC. # \_\_\_\_\_  
STATE \_\_\_\_\_ ZIP \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
REFERRED BY \_\_\_\_\_ AGE \_\_\_\_\_  
SEX             Female     Male            EMPLOYER \_\_\_\_\_  
MARITAL STATUS             Single         Married            OCCUPATION \_\_\_\_\_  
                                          Divorced     Widowed     Separated            only if minor- NAME OF PARENTS \_\_\_\_\_  
NAME OF SPOUSE \_\_\_\_\_

**INSURANCE INFORMATION**

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PRIMARY PHYSICANS NAME \_\_\_\_\_  
PRIMARY INS. COMPANY NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_ TEL.# \_\_\_\_\_  
POLICYHOLDER NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT' \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_ SOCIAL SEC.# \_\_\_\_\_  
POLICY/ID # \_\_\_\_\_ GROUP NAME/ NUMBER \_\_\_\_\_  
  
SECONDAY INS. COMPANY NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_ TEL.# \_\_\_\_\_  
POLICYHOLDER NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT' \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_ SOCIAL SEC.# \_\_\_\_\_  
POLICY/ID # \_\_\_\_\_ GROUP NAME/NUMBER \_\_\_\_\_

**HEALTH QUESTIONNAIRE**

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**SKIN**

- Skin disease  YES  NO
- Jaundice  YES  NO
- Hives, eczema or rash  YES  NO
- Freq. infection or boils  YES  NO
- Abnormal pigmentation  YES  NO

**HEAD-EYES- EARS- NOSE- THROATS**

- Eye disease or injury  YES  NO
- Do you wear glasses?  YES  NO
- Double vision  YES  NO
- Headaches  YES  NO
- Glaucoma  YES  NO
- Itching eyes or nose  YES  NO
- Sneezing or runny nose  YES  NO
- Nose bleeds  YES  NO
- Chronic sinus trouble  YES  NO
- Ear disease  YES  NO
- Impaired hearing  YES  NO
- Dizziness or transient episodes of unconsciousness  YES  NO

**NECK**

- Stiffness  YES  NO
- Thyroid trouble  YES  NO
- Enlarged glands  YES  NO

**NEURO-PSYCHIATRIC**

- Have you ever had psychiatric care  YES  NO
- Have you been advised to see Psychiatrist  YES  NO
- Do you ever have, or have had, fainting spells  YES  NO
- Paralysis  YES  NO

**CARDIOVASCULAR**

- Chest pain or angina pectoris  YES  NO
- Shortness of breath with walking or lying down  YES  NO
- Difficulty walking two blocks  YES  NO
- Heart troubles or Heart attacks  YES  NO
- High blood pressure  YES  NO
- Swelling of hands, feet, or ankles  YES  NO
- Awaking in the night smothering  YES  NO
- Heart murmur  YES  NO

**GASTROINTESTINAL**

- Peptic ulcer (stomach or duodenal)  YES  NO
- Vomiting blood or food  YES  NO
- Gallbladder disease  YES  NO
- Liver trouble  YES  NO
- Painful bowel movements  YES  NO
- Bleeding with bowel movements  YES  NO
- Black stool  YES  NO
- Hemorrhoids or piles  YES  NO
- Recent change in bowel habits  YES  NO
- Frequent diarrhea  YES  NO
- Heartburn or indigestion  YES  NO
- Cramps or pain in the abdomen  YES  NO

Does food stick in throat  YES  NO

NAME \_\_\_\_\_ AGE \_\_\_\_\_

**GENTOURINARY**

- Loss of urine  YES  NO
- Frequent urination  YES  NO
- Nighttime urination  YES  NO
- Burning or painful urination  YES  NO
- Blood in urine  YES  NO
- Kidney trouble  YES  NO
- Kidney stones  YES  NO

**GYNECOLOGICAL**

- Age periods started \_\_\_\_\_
- How long do periods last? \_\_\_\_\_ days
- Number of pregnancies \_\_\_\_\_
- Number of miscarriages \_\_\_\_\_
- Date of last cancer smear and results \_\_\_\_\_
- Frequency of periods, every \_\_\_\_\_ days
- Any pain with your periods  YES  NO
- Date of last mammogram \_\_\_\_\_
- Date of first day of last period \_\_\_\_\_

**MUSCULOSKELETAL**

- Varicose Veins  YES  NO
- Weakness of muscles or joints  YES  NO
- Any difficulty in walking  YES  NO
- Any pain in calves or buttocks  YES  NO

**RESPIRATORY**

- URI (cold)  YES  NO
- Spitting up blood  YES  NO
- Chronic freq. Cough  YES  NO
- Asthma or wheezing  YES  NO
- Difficulty breathing  YES  NO
- Any trouble with lungs  YES  NO
- Pleurisy or Pneumonia  YES  NO

**HEMATOLOGIC**

- Are you slow to heal after cuts  YES  NO
- Blood disease  YES  NO
- Anemia  YES  NO
- Phlebitis  YES  NO
- Have you had bleeding after Tooth surgery or exactraction  YES  NO

**ENDOCRINE**

- Thyroid disease  YES  NO
- Hormone therapy  YES  NO
- Any change in hat of glove size  YES  NO
- Any change in hair growth  YES  NO
- Have you become colder than before or skin become dryer  YES  NO

**ALLERGIC**

- Asthma  YES  NO
- Arthritis  YES  NO
- Nasal congestion  YES  NO
- Hives / Rashes  YES  NO
- Fatigue  YES  NO
- Sinusitis  YES  NO
- Headaches  YES  NO
- Hay fever  YES  NO
- Itchy eyes  YES  NO

## ENERGETIC HISTORY

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Mark your favorite:	FLAVOR	SEASON	COLOR
	Sour	Spring	Blue
	Bitter	Summer	Red
	Sweet	Indian Summer	Yellow
	Spicy	Fall/ Autumn	White
	Salty	Winter	Black

At what time of the day or night are your symptoms worse? \_\_\_\_\_ AM/ PM

Do you prefer to be inside or outside? \_\_\_\_\_

Do weather changes affect you?  NO  YES- How? \_\_\_\_\_

Do you sleep well?  YES  NO, elaborate \_\_\_\_\_

What is your energy level? worst 1 2 3 4 5 best

What makes your symptoms better? \_\_\_\_\_

worse? \_\_\_\_\_

What was the most significant medical or emotional occurrences in your life? \_\_\_\_\_

On a scale of 1- 10, what do you rate your present stress level? \_\_\_\_\_

What are the stressors in your life? \_\_\_\_\_

What is your greatest fear? \_\_\_\_\_

What makes you really happy? \_\_\_\_\_

## NUTRITIONAL HISTORY

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What do you eat and drink for:

Breakfast- \_\_\_\_\_

Lunch- \_\_\_\_\_

Dinner- \_\_\_\_\_

Snacks- \_\_\_\_\_

Do you have food allergies?  NO  YES- What are they? \_\_\_\_\_

Do you have any digestive problems? \_\_\_\_\_

Do you have regular bowel actions? \_\_\_\_\_

Do you feel sleepy or tired after eating? \_\_\_\_\_

Are you able to fast without symptoms? \_\_\_\_\_

## SOCIAL HISTORY

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What city do you live in? \_\_\_\_\_

Do you have children?  NO  YES- How many? \_\_\_\_\_

Do you have pets?  NO  YES- How many and what kind? \_\_\_\_\_

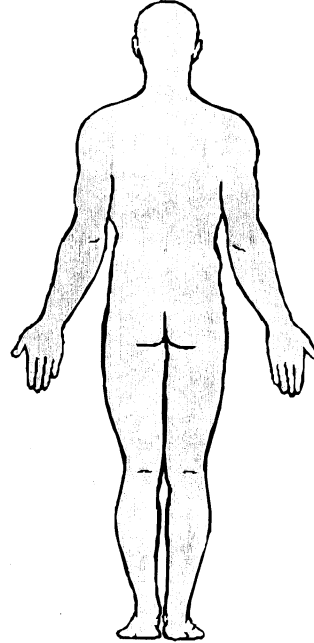
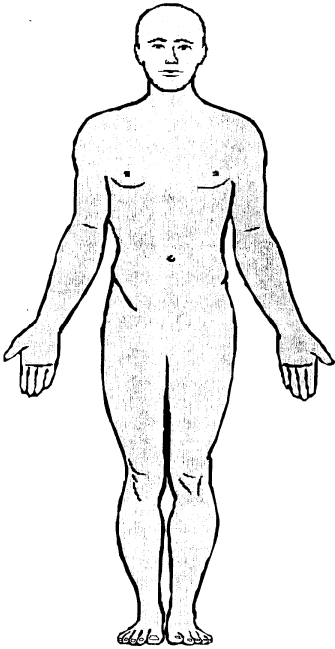
Do you smoke?  NO  YES- How much? \_\_\_\_\_

Do you drink alcohol?  NO  YES- How much? \_\_\_\_\_

**IF YOU ARE HAVING PHYSICAL PAIN, PLEASE COMPLETE THIS PAGE**

PAIN DIAGRAM

aa: ACHING pp: PINS & NEEDLES nn: NUMBNESS ss: STABBING bb: BURNING



What do the following activities do to your pain?

	Relieves	Worsens	No Change
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending backwards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Side Bending Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking Upstairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How is your pain during the course of the day? On a scale of 0(no pain) – 10(unbearable).

Morning \_\_\_\_\_  
 Afternoon \_\_\_\_\_  
 Evening \_\_\_\_\_  
 Night \_\_\_\_\_

How bad was your pain when you originally started? \_\_\_\_\_  
 What is your pain level right now? \_\_\_\_\_  
 Who first treated you? \_\_\_\_\_  
 Medication used? \_\_\_\_\_  
 How many doctors have you seen? \_\_\_\_\_  
 Did the treatment work? \_\_\_\_\_  
 Have you received physical therapy? \_\_\_\_\_  
 If yes, how many times a week, for how many weeks? \_\_\_\_\_

## PATIENT CONSENT FORM AND OFFICE POLICIES

I \_\_\_\_\_ authorize Dr. George Mars to perform the following procedures:

### ACUPUNCTURE

I have informed the Doctor of all the medications that I am currently taking, including birth control, blood thinners, vitamins, herbs, and all other prescription and over-the-counter medications. **I understand the explanation below is only a precaution and awareness.** I have been informed that the side effects of **acupuncture** may include localized pain infection, bleeding at the site of insertion, bruising, needle shock (a faint feeling or actual fainting), and possible collapsed lung. I have also been informed I may experience a calming effect or fatigue. I have been informed the Doctor has given a 24 hour restriction, after acupuncture as follows; no heavy meals, no alcohol, no hot or cold beverages, or no strenuous activity (including exercise and sexual activity). I understand the explanation above is only a precaution and awareness.

I have been informed that for treatment of chronic pain problems, it may require up to 6 treatments before any effect is experienced and that a course of 6 to 10 treatments is generally required for maximum effect. I understand that initial appointment may take up to an hour and a half; follow-up appointments may take up to an hour and will usually be in one to two weeks. Appointments will vary depending on the individual complaint and course of treatment. I understand that no guarantee has been made that the procedure will improve my condition, and that the procedure may make my condition worse.

### EMG/ NCS (ELECTROMYOGRAPHY)

I have informed the Doctor of any blood thinning medication I am taking and/or having a pacemaker or have hemophilia. I have been informed that the EMG test consists of small thin needles inserted into several muscles to see if there are any problems. I have been informed the Doctor will use a new needle and will disposed of the needle in a Sharps container after each time. I have been informed that I may experience a small amount of pain when the needle is put in. I have been informed that treatment may take 45 to 60 minutes. I have been informed not to wear lotion on the body part that is going to be tested and I may perform my normal activities, such as eating, driving, and exercising before and after the test.

I have been informed that NCS shows how the body's electrical signals are traveling to a nerve. This is done by applying small electrical shocks to the nerve and recording how the nerve works.

### EVALUATION

I have been informed that the Doctor will give me a physical exam, we will discuss my medical history, and the Doctor will make recommendations for further care.

● This may include Chinese herbs and nutraceuticals that will be prescribed to you, the cost of these will be your responsibility at time of visit; no insurance company will reimburse you.

● **After – hours Availability:** Since we do not offer either urgent or emergency care. We require that all patients have a Primary Care Provider. If you think that either the herbs or nutraceuticals are causing a new symptom, discontinue these medications immediately. Wait and watch for changes in your symptoms, and call this office on the next working day.

My signature certifies that I have read and understand the statements above.

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

If patient is a minor, signature of parent or legal guardian

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

## STANDARD PATIENT WAIVER FORM

As a condition of servicing the health care needs of the below referenced patient, I (the patient, legal guardian, subscriber) hereby attest that the patient is an "Eligible" member of the health plan listed below as of the date of service. I further hereby attest and agree that, should the patient later be determined "ineligible" for the services rendered by this provider, I shall comply with the demands of payment to provider.

### IDENTIFYING INFORMATION (PLEASE PRINT):

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

NAME OF INSURANCE COMPANY(S): \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ ID #: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

NOTES: \_\_\_\_\_

\_\_\_\_\_

*I hereby confirm that the above information is true and correct. I also agree to pay provider for services rendered if the Health Plan determines that I am not eligible for services rendered on this date of service.*

\_\_\_\_\_  
Signature of Patient/Subscriber/Guardian

\_\_\_\_\_  
Relationship/Self

\_\_\_\_\_  
Date