Gao Acupuncture

5776 Stoneridge Mall Rd. #230
Pleasanton, CA 94588

Tel: 925-735-1818
www.gacacu.com

New Patient Forms and Medical History

*Last Name: _____ *First Name:_____ Date:_____

*Address: _____ City: _____ State: ____ Zip: _____

*Home Phone: _____ Cell Phone: _____ Preferred #: H / C

May we leave a voicemail? Yes/ No *Please Initial _____
May we send you a text message? Yes / No *Please Initial _____

Email: _____ Appointment reminders? Yes / No
Please note that Email is **not** HIPAA compliant. Our emails will be used for appointment reminders only. If you would like to send an email regarding your treatment you will need to release your HIPAA rights. *Please Initial _____

*Date of Birth: _____ Height: _____ Weight: _____ Occupation: _____

Martial Status: Married / Single / Domestic Partner / Divorced / Other _____

*Emergency Contact:
Name:_____Phone #: _____ Relationship:_____

How did you hear about us? _____
Referred by: _____ Phone Number: _____

Healthcare & Insurance

Primary Care Physician: _____ Phone Number: _____
Address: _____
If needed, may we communicate with your primary care physician? Yes / No *Please Initial ____

Insurance Company: _____ Phone Number: _____
Policy Holder's Name: _____ Date of birth: _____
Group #: _____ Member ID: _____

Worker's Comp: Yes / No Auto Accident: Yes / No

*Please list all medications you are currently taking:

Medication Name:	Instructions:	Dosage:

Please list any herbs you are taking:

_____

Please list all of your vitamins or supplements:

_____

What brings you in Today?

_____

_____

How long have you had this condition?

_____

Have you had a similar condition like this in the past? No / Yes, _____

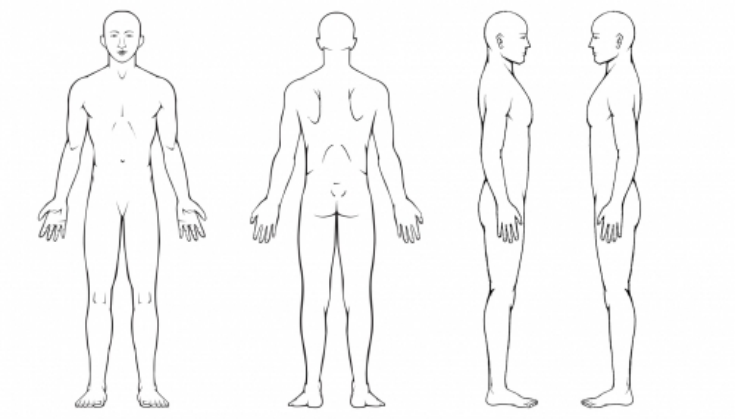
Does anything aggravate this condition?

_____

Do you smoke? No / Yes, how often? _____

Pain Level: 1 2 3 4 5 6 7 8 9 10 | Energy Level: 1 2 3 4 5 6 7 8 9 10

Please place an X on all areas of concern:



Acknowledgement of Notice of Privacy Practices

5776 Stoneridge Mall Rd.
Pleasanton, CA 94588
925-735-1818

We respect your right to privacy and understand that your medical information is personal to you. Your personal health information is confidential and this notice is intended in summary to help you understand how our practice uses and discloses your personal health information and what right you have with respect to your medical information.

How we may use and disclose your information:

Treatment:
We may disclose your medical information to doctors, nurses, technicians, or any other medical staff that will be caring for you. Also, we may share medical information to your other Healthcare Providers to better assist them in treating your condition.

Primary Care Physician Name: _____ Tel:_____
Address: _____

Other Healthcare Providers, Name:_____Tel: _____
Address: _____

Payment:
We may need to disclose personal health information about you with your insurance provider in order to determine if payment for treatment is covered by your plan.

Appointment Reminders:
Our practice may use and disclose medical information about you to provide you with reminders for your upcoming appointment. If you have any special requests about these reminders, please notify us.

I hereby authorize Hongmei Gao L. Ac or medical staff to leave a message at the following:

Phone Number: _____ H / C / W

If you would like your protected health information disclosed to a family member or friend, please indicate their name, phone number and their relationship to you.

Name: _____Tel: _____ Relationship: _____
Name: _____Tel: _____ Relationship: _____

I hereby acknowledge that I have throughly read this Notice of Privacy Practices.

Signature: _____ Date: _____

Print Name: _____

Please check all that apply:

Digestion:
☐Normal □ Bloating (feel full quickly) □ Gassy □ Frequent Belching/Burping
☐ Pain/Cramping □ Nausea/Vomiting □ Heartburn

Appetite Level: How hungry are you during the day?

□ High □ Normal □ Low

☐No desire to eat

Bowel Movement: How often do you go a day? _____

□ Normal □ Loose □ Bloody

□ Dry/Hard □ Diarrhea
☐Difficult to push

Urination: About how often do you go per day? _____

□ Normal/Clear □ Dark Yellow

□ Dark Red □ Foul Odor
☐Burning □ Urgency □ Frequency

Quality of Sleep: Do you feel Refreshed? Yes / No

□ Normal □ Tired □ Sleepy all day

□ Wake up often □ Frequent dreams
☐Difficult to fall asleep

Have you had Acupuncture before? Yes / No
If so, why and was it successful? _____

FEMALES ONLY:

Please Circle all that apply:

Cramping - Breast Tenderness - Moodiness - Fatigue - Back Pain

Abdominal Pain - Headaches - Irritability - Anxiety - Sadness - Spotting

Do you have a monthly Menstrual Cycle? Yes / No

Are you Pregnant? Yes / No | First day of last Menstrual Cycle: _____
On average, how is your flow? ☐ Heavy ☐ Light ☐ Moderate
How many days does it usually last? 1 2 3 4 5 6 7 8 9 10+