Jera Wellness
210 W. Main St. Suite 101. Tustin. CA 92780
Phone. 714. 788. 1126 Fax. 714. 656. 0509

PATIENT INFORMATION

Name : [M F]	DOB :
Social Security # :	Driver's Licence # :
Marital status : S M D	Spouse's name :
Home Address :	
Phone : (Home)	(Cell)
E-Mail :	
Occupation :	Phone :
Primary Care Doctor :	Specialty :
Emerge. Contact & Relationship :	Phone :
Insurance Company :	Policy # :
Cancellation Policy I acknowledge that I will give at least 24 hour notice of cancellation to avoid a charge for the session. This is a courtesy to other patients who may need that appointment time. I will call if I anticipate being more than 15 minutes late for my appointment. Initials _____	

MAJOR COMPLAINT

_____ Severe Moderate Slight☐

PAST MEDICAL HISTORY

	Yes	No		Yes	No
AIDS	□	□	Gallstones	□	□
Anxiety Attacks	□	□	Gastric/Duodenal Ulcers	□	□
Asthma	□	□	German Measles (Rubella)	□	□
Autoimmune Disease	□	□	Glasses/Contact lenses	□	□
Birth Defects	□	□	Heart Attack	□	□
Bladder Infections	□	□	Heart Disease	□	□
Blood Disorders	□	□	Heart Murmur	□	□
Breast Tumor or Cancer	□	□	Hepatitis	□	□
Bronchitis	□	□	High Blood pressure	□	□
Cancer	□	□	Intestinal Bleeding	□	□
Cirrhosis	□	□	Kidney Infection	□	□
Connective Tissue Disorders	□	□	Kidney Stones	□	□
Diabetes	□	□	Lupus Erythematosis	□	□
Epilepsy	□	□	Migraine	□	□

Patients	Date

	Yes	No		Yes	No
Neurologic Disorders	□	□	Prolonged Dizziness	□	□
Other Forms of Arthritis	□	□	Rheumatic Fever	□	□
Other Heart Conditions	□	□	Rheumatoid Arthritis	□	□
Other Kidney Problems	□	□	Seizures	□	□
Other Lung Problems	□	□	Thyroid Problems	□	□
Panic Attacks	□	□	Tuberculosis	□	□
Paralysis	□	□	Varicose Veins	□	□

FEMALES:

Form of birth control_____ Pregnant □Yes □No ☐ □ Clotting ☐ □ Hot flashes

Last period_____ Last PAP test_____ □ Heavy bleeding ☐ □ Vaginal dryness

Age started menstrual cycle_____ Age stopped_____ □ Vaginal discharge

□ Other:_____

□ Menstrual pain ☐ □ Water retention No. Pregnancies _____

□ Low backache ☐ □ Mood changes No. Vaginal Deliveries_____ No. Miscarriages_____

□ Irregular □ Painful breast No. Caesareans_____ No. Abortions_____

MEDICAL CONDITIONS conditions & surgeries & auto accidents you have or have had and year diagnosed.		**ALLERGIES** Medications, Seasonal, Environmental, Food	**OCCUPATIONAL CONCERNS** Check (√) if your work exposes you to the following
Year	Condition/Surgery		Occupation:
			□ Stress
			□ Heavy Typing/Computer Use
			□ Hazardous Substances
			□ Heavy Lifting
			□ Other :

MEDICATIONS				
Prescription name	Purpose	How long	Dose / How often	Last Dose

Patient	Date

AVERAGE DAILY DIET

Morning : _____

Afternoon : _____

Evening : _____

HABITS *[Check (V)]*

□ Cigarettes □ Coffee □ Tea □ Soda □ Alcohol □ Drugs

□ Sugar □ Salt □ Other _____

FAMILY MEDICAL HISTORY

□ Diabetes □ Cancer □ High Blood Pressure □ Heart Disease □ Stroke

□ Asthma □ Allergies □ Alcoholism □ Other _____

SYMPTOMS *For each symptom you currently have, rate its severity from 1-5 (5 being the worst). Leave blank if N/A.*

GENERAL

___ Chills
___ Fevers
___ Nervousness
___ Lack of sweating
___ Aversion to cold
___ Cold back
___ Low energy
___ Fatigue
___ Numbness
___ Weight loss
___ Aversion to heat
___ Cold abdomen
___ Dizziness
___ Excess thirst
___ Sweat spontaneously
___ Weight gain
___ Cold hands
___ Allergies
___ Insomnia
___ Night sweating
___ Bleed / bruise easily
___ Cold feet

☐

SKIN / HAIR☐

___ Rashes
___ Eczema
___ Change in hair/skin texture
___ Tumors, Masses or Lumps
___ Ulcerations
___ Pimples
___ Purpura
___ Hives
___ Dandruff
___ Boils
___ Other _____
___ Itching
___ Loss of hair

☐☐

HEAD / FACE☐

___ Dizziness
___ Eye strain
___ Color blindness
___ Ringing in ears
___ Earaches
___ Tooth problems
___ Sores on lips or tongue
___ Other head or neck problem
_____
___ Concussions
___ Eye pain
___ Cataracts
___ Poor hearing
___ Dry throat
___ Jaw clicks
___ Headaches
___ Poor vision
___ Blurry vision
___ Nose bleeds
___ Dry mouth
___ Grinding teeth
___ Recurrent sore throats
___ Glasses / contacts
___ Night blindness
___ Sinus problems
___ Copius saliva
___ Facial pain

CARDIOVASCULAR

___ High blood pressure
___ Dizziness
___ Blood clots
___ Low blood pressure
___ Fainting
___ Phlebitis
___ Chest pains
___ Cold hands/feet
___ Difficulty breathing
___ Irregular heart beat
___ Hands/feet swelling
___ Other C/V /problem

Patients	Date

RESPIRATORY

___ Asthma ___ Bronchitis ___ C.O.P.D ___ Pneumonia

___ Cough ___ Coughing blood ___ Tight chest

___ phlegm : color _____ (how often)

___ Other lung problem _____ _____

GASTROINTESTINAL

___ Nausea ___ Vomiting ___ Diarrhea ___ Bowel Movement :

___ Gas ___ Belching ___ Black stool _____Frequency

___ Bad Breath ___ Rectal pain ___ Hemorrhoids _____ Color

___ Constipation ___ Bloody stools ___ Sensitive abdomen _____Odor

___ Pain or cramps ___ Laxative use. Freq. of Use : _____ _____Form

MUSCULOSKELETAL

___ Neck pain ___ muscle pains (where) _____

___ Back pains (where) _____ ___ Joints pains (where) _____

___ Other _____

NEUROPSYCHOLOGICAL

___ Seizures ___ Areas of numbness ___ Poor memory ___ Concussion

___ Depression ___ Anxiety ___ Bad temper ___ Easily stressed

___ Treated for emotional problems ___ Considered / Attempted suicide

___ Other neurological problems _____

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INFORMED CONSENT FOR ACUPUNCTURE TREATMENTS

I, _____ hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including moxibustion, cupping, and/or electro-acupuncture by the above-named doctor or another duly authorized doctor in the clinic.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding, or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needs are to be used. All acupuncture needles are properly disposed of after each and every treatment.

I do no expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

I have read the above consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present future conditions for which I seek treatment..

Female Patients:

I fully understand that in the case of pregnancy,
a risk of causing fetal distress with acupuncture treatment(s) is possible.
I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

Please initial your name here if you understand the above and accept treatment : _____

Our office accepts the insurance plan that covers acupuncture. The patient is responsible for his/her own deductible and co-pay amount, as well as for services not covered by the insurance plan.

I authorize the release of any medical information necessary to process insurance claims and the use of this signature on all insurance submissions. I fully understand that I am financially responsible for all medical bills for services rendered.

_____	_____	_____
Date signed	Print Patient's Name (Or Parent / guardian)	Signature of Patient (Or Parent/guardian)