NATURAL HEALING & ACUPUNCTURE INC.
Acupuncture • Herbal Medicine • Nutrition • Massage NaturalHealingAcupuncture.com
2001 S. Barrington Ave. Suite 220, Los Angeles, CA 90025 P: 310-473-7474 F: 310-473-9767
Denise Wiesner, L.Ac. • Alex Berks, L.Ac. • Katya D. Mosely, L.Ac.

Dear Patient,

Welcome to Natural Healing & Acupuncture. In an effort to provide you with the most caring and efficient treatment, below are some guidelines to prepare you for your first visit.

• **Before Your First Visit:** Fill out and sign all of the attached forms before your appointment. Bring your new patient forms with you when you come in for your first visit. Please do not hesitate to discuss any questions you might have with us.

• **The Initial Visit**: Wear comfortable and loose fitting clothes. The practitioner will address your concerns, take a detailed history, and devise a treatment plan. This process takes approximately 1 hour. Please allow an additional 30-45 minutes for acupuncture. At the end of your visit you will receive any herbs or nutrients as appropriate. Subsequent visits will take one hour.

• **Cancellations**: We understand that circumstances arise that may prevent you from keeping an appointment. We would prefer 48 hours notice, but require 24 hours notice for cancellation. If the required notice for rescheduling or cancellation is not timely received, you will be charged for your missed appointment. In the event that you arrive more than 15 minutes after your appointment time, we may need to reschedule you.

• **Insurance**: We accept insurance and are happy to verify your coverage. If you intend to use your insurance plan, please bring your insurance card and a picture ID to your first appointment.

• **Payment**: Full payment, in the form of **cash or check** is required at the time services are provided.

• **Parking:** There is paid parking in the building for $1.50/30 minutes, and street parking on surrounding streets. Please be aware of street cleaning and other parking restrictions. Parking in the building is free after 6pm and on weekends.

Again, welcome to Natural Healing & Acupuncture. We look forward to addressing your medical concerns naturally and effectively. Please feel free to give us feedback on any aspect of our service, so that we may provide the best care possible.

Much health,

Katya D. Mosely, L.Ac.
Natural Healing & Acupuncture

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PATIENT RECORD

NAME: _____ DATE OF BIRTH: _____
HOME ADDRESS:_____ CITY _____ ZIP _____
SEX: M/F/T AGE: _____ REFERRED BY: _____
HOME PHONE: _____ WORK PHONE: _____
CELL PHONE: _____ EMAIL: _____
OCCUPATION: _____ EMPLOYER: _____
WORK ADDRESS: _____ CITY_____ STATE ____ ZIP _____
EMERGENCY CONTACT'S NAME: _____ PHONE: _____
YOUR DOCTOR'S NAME: _____ SPECIALTY: _____
DOCTOR'S PHONE NUMBER: _____ INSURANCE COMPANY: _____
NAME OF INSURED: _____ ID#: _____
GROUP #: _____ PROVIDER PHONE #: _____
IS YOUR CONDITION DUE TO: (circle one) ACCIDENT JOB INJURY OTHER

FOR ACUPUNCTURE PATIENTS PLEASE ANSWER THE FOLLOWING BEFORE TREATMENT:

1. Do you have a tendency to faint?	yes	no
2. Do you have a pacemaker?	yes	no
3. Do you bleed for a long time?	yes	no
4. Have you ever had hepatitis?	yes	no
5. Are you HIV+?	yes	no
6. (Women) Are you pregnant?	yes	no

OUR OFFICE POLICY

For patients without insurance: It is customary to pay for professional services when rendered.
For patients with insurance: We will accept your insurance assignment whenever possible, as soon as your coverage is verified. We will file your claim forms and assist you in every way we can. It may be necessary for us to charge a co-pay for services rendered if your insurance policy does not cover the full cost of the treatment. **If you must cancel an appointment, please inform the office at least 24 hours in advance to avoid a full charge of service. A missed appointment without 24-hour notice will be charged for the treatment in full.**

_____ _____

Patient's Signature **Date**

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Initial Evaluation Form

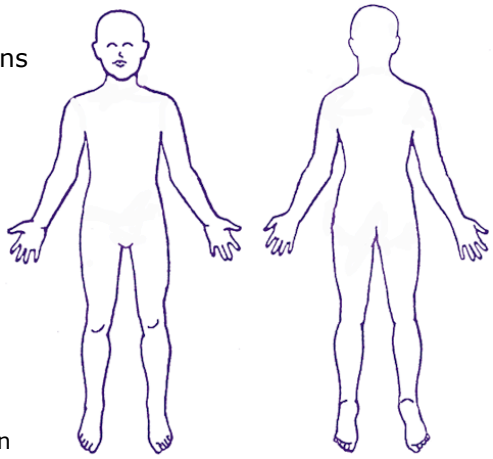
Note: This is a confidential record of your medical history. Information contained here will not be released without your authorization.

Name: _____ Date:_____

Date of birth: _____ Age:_____ Height: _____ Weight: _____

Please indicate your chief complaint & how long you've had the condition

_____



Please list other health concerns & how long you've had the conditions

1. _____
2. _____
3. _____
4. _____

If you experience pain, rate on a scale of 1-10 (Circle one)

Less pain more pain

1 2 3 4 5 6 7 8 9 10

minimal slight moderate severe

Have you had this condition in the past? _____

What makes it better? _____

What makes it worse? _____

Is your condition: (circle one) Getting worse constant comes and goes

Medications and doses you are currently taking:

_____

_____

Herbs and/or supplements you are currently taking:

_____

List surgeries, operations, and/or hospitalizations you have had and when?

_____

Date of your last physical examination _____By whom? _____

Medical History (Do you have or have you ever had):

☐ Arthritis	☐ Epilepsy	☐ Fibromyalgia/Fatigue
☐ Asthma	☐ Stroke	☐ Hepatitis
☐ Anemia	☐ Kidney or Bladder trouble	☐ Jaundice
☐ Heart trouble	☐ Gallstones	☐ Sudden Weight Gain
☐ Cancer	☐ Ulcers	☐ Sudden Weight Loss
☐ Diabetes	☐ High Blood Pressure	☐ HIV+

Other:_____

Family History: (Has any member of your family had any of the above?) Yes No
If yes, which member and what did they have? _____

Energy Level:
Please rank your overall energy level on a scale from 1 (low) to 10 (high):

1 2 3 4 5 6 7 8 9 10
minimal slight moderate severe

Do you experience an energy slump: after meals afternoon

Stress: What causes it?
_____

Please rank your overall stress level on a scale from 1 (low) to 10 (high):

1 2 3 4 5 6 7 8 9 10
minimal slight moderate severe

Sweating:

☐ Night Sweats	☐ Excessive Sweating
☐ Rarely sweat	☐ Sweating with slight exertion

Circulation: Feelings of:

☐ Hot areas? _____	☐ Cold limbs	☐ Bleed easily
☐ Cold areas? _____	☐ Bruise easily	

Other:_____

Skin:

□ Dry Itchy	□ Frequent rashes	□ Dry scalp
□ Moist/Clammy	□ Hair thinning	□ Bruise easily
□ Burning	□ Acne	□ Hives

Other:
_____

Scars: (list all scars from accidents and surgeries)
_____

Sleep: (circle all that apply): Trouble Falling Asleep Staying asleep Excessive dreaming

Other sleep concerns: _____

How many hours do you sleep per night?_____

Head: Headaches (what area?)

_____

□ Dizzy □ Memory loss □ Loss of balance

Other:_____

Eyes:

□ Eye pain □ Blurred Vision □ Dry eyes □ Darkness under eyes

Other:_____

Ears:

□ Poor hearing □ Earaches □ Ear Infections □ Ear Ringing

Other:_____

Nose:

□ Frequent nose bleeds □ Sinus trouble □ Frequent colds

Other:_____

Throat:

□ Sore Throat □ Difficulty swallowing □ Swollen tongue
□ Hoarseness □ Jaw problems □ Dry mouth & throat
Other:_____

Chest:

□ Hard to breathe □ Pain/pressure in chest □ Persistent cough
□ Wheezing □ Trouble breathing at night □ Coughing blood
□ Shortness of breath □ Palpitations □ Coughing phlegm
Other:_____

Bowels:

□ Diarrhea □ Black stools □ Lower bowel gas
□ Constipation □ Mucus in stools □ Stools have foul odor
□ Bloody stools □ Hemorrhoids □ Colon problems

Number of bowel movements per day _____

Urine: Color _____ Amount _____

□ Frequent Urination
  o Daytime
  o At night
□ Strong smelling urine
□ Hard to urinate
□ Pain or burning on urination
□ Frequent infection
□ Water retention
□ Blood in urine

Musculoskeletal: Pain in:

□ Neck □ Upper back □ Weakness in legs
□ Shoulder □ Mid back □ Weak ankles
□ Between shoulders □ Lower back □ Stiff all over
□ Arms/hands □ Bones sore/painful □ Tingling in feet
□ Hip □ Loss of grip □ Muscle spasm/cramps
□ Knee □ Swollen knees/elbows □ Loss of feeling in hands/feet
□ Fingers □ Leg cramps at night □ Bursitis
□ Big toe □ Painful joints

Neurological:

□ Nervousness
□ Depressed
□ Easily angered
□ Easily irritated
□ Frequent crying
□ Worry/anxiety
□ Mood swings
□ Memory confusion
□ Poor concentration
□ Suicidal
□ Tremors
□ Numbness/tingling in limbs
□ Poor coordination
□ Muscle weakness
□ Feel weak and shaky
□ Seizures
□ Nerve pain
□ Shingles

Other: _____

Females: Last period _____ Last PAP test _____ Form of birth control _____

Age started menses _____ Age stopped _____

No. Pregnancies _____ No. Deliveries _____ No. Miscarriages _____ No. Abortions _____

□ Menstrual pain
□ Low backache
□ Painful periods
□ Clotting
□ Water retention
□ Mood changes
□ Miss periods
□ Irregular periods
□ Ovarian cysts
□ Fibroids
□ Endometriosis
□ Low or no sex drive
□ Painful breasts
□ Heavy bleeding
□ Light scanty bleeding
□ Hot flashes
□ Food cravings
□ STDs
_____

Color of menses: _____

Discharge:
□ Yellow
□ Thick
□ White
□ Odor
□ Itching
□ Copious

Males:
□ Low sex drive
□ Lack of sex drive
□ Impotence
□ Ejaculation causes pain
□ Discharges
□ Premature ejaculation
□ Pain or burning while urinating
□ Prostate trouble

Appetite:
□ Excessive appetite
□ Poor appetite
□ Appetite keeps changing
□ Feel tired or weak if meal is missed
□ Excessive thirst
□ Never thirsty

Do you have any specific food cravings?
_____

Digestion:
□ Stomach gas
□ Lower bowel gas
□ Heartburn
□ Burning/belching
□ Stomach pain
□ Stomach cramps
□ Nausea
□ Vomiting
□ Bad breath
□ Sores in mouth
□ Weight gain
□ Weight loss
□ Bitter taste in mouth
□ Sour taste in mouth
□ Food Allergies
□ Abdominal bloating
How long after eating?
_____

Nutrition: List some of your favorite foods_____

Do You:

□ Skip breakfast □ Eat a snack □ Eat a hearty breakfast □ Eat with 2 hours of sleeping?

How many meals a day do you eat? _____ When is your biggest meal? _____

How many glasses of water do you drink per day? _____

Do you use:

□ Alcohol - amount per week _____ Type _____

□ Caffeine – amount per week _____ Type _____

□ Drugs – amount per week _____ Type _____

□ Tobacco - No. of packs per day _____ How many years? _____

Are you:
□ Satisfied with your current diet & eating habits
□ Interested in improving your diet and eating habits

Do you:
□ Eat raw fruits and vegetables at least 2x/day?
□ Eat green or yellow vegetables at least 2x/day?
□ Eat frequently between meals?
□ Chew your food thoroughly before swallowing it?
□ Drink juice, milk or other drinks instead of water when thirsty?
□ Always add salt?
□ Eat meat or dairy products 2 or more times/day?
□ Eat the same foods almost every day?
□ Eat when you are not hungry?
□ Eat until you feel full?
□ Occasionally go on a crash diet?

Are you allergic to any of the following:
□ Medicine _____
□ Herbs _____
□ Foods _____
□ Other _____

Please describe any other health concern you would like to address:

_____

_____

_____

_____

_____

_____

I HEREBY CERTIFY THAT THE PRECEEDING QUESTIONS HAVE BEEN ANSWERED TRUTHFULLY AND COMPLETELY TO THE BEST OF MY KNOWLEDGE.

Patient's Signature _____Date _____