A Center for Natural Healing
1817 Pruneridge Avenue
Santa Clara, CA 95050

408.244.8565 phone
www.acenterfornaturalhealing.com
669.221.5866 text

PATIENT INFORMATION

Name: ____Age:_______________

Address:________________________________ Birth date:_______/________/_________

City:____________________________ State: _________ Zip Code:_______________

Cell Phone: (________)_________-_____________ Home Phone: (______)_________-_____________

Email Address:____

Would you like to join a loving, warm, and supportive community? We send free helpful insights from Dr. Setareh & Salvador occasionally (about twice a month) in support and addition to your treatments ☺

Yes / No

(we respect your privacy)

Employer: ____________________________Work Phone: (______)_________-___________

Work address:____

City:______________________________State: _________ Zip Code:_______________

Emergency Contact:____

Address:_____________________________________Relationship: _______________

City:___________________________ State: _________ Zip Code:_______________

Home Phone: (______)_________-___________ Work Phone: (________)_________-_____________

CONFIDENTIAL HEALTH HISTORY

Primary reason(s) you are coming to see us:___________________________________

When and how did you develop this condition?________________________________

Have you had this condition in the past? ... NO/... YES If yes, when?______________________

What treatment have you received for this condition?_____________________________

What other healthcare are you currently receiving?______________________________

Primary Care MD____

When was your last physical exam?___________________

Your most recent blood pressure reading was: normal_____ high_____ low_____

Height:________________ Current Weight:________________

Please check the applicable answer to the following questions:

Have you had acupuncture before? ... NO/... YES
Do you catch colds easily? ... NO/... YES
Do you often feel thirsty? ... NO/... YES
Do you bruise or discolor easily? ... NO/... YES
Do you have a tendency to feel hot? ... NO/...YES

Are you currently pregnant? ... NO/... YES
Do you sweat easily? ... NO/... YES
Do you get hungry easily? ... NO/... YES
Do you have any problems sleeping? ... NO/... YES
Do you have a tendency to feel cold?... NO/... YES

How would you describe your stress level? ... low ... moderate ... normal ... high
How would you describe your energy level? ... low ... moderate ... normal ... high

OPERATIONS AND HOSPITALIZATIONS

1 Date: ___________________________________ Diagnosis:___________________________________

2 Date: ___________________________________ Diagnosis:___________________________________

3 Date: ___________________________________ Diagnosis:___________________________________

MEDICATIONS (List all prescriptions and over-the-counter drugs used during the past year)

____

____

What herbal/nutritional supplements are you currently taking?

____

____

LIFESTYLE

How many meals do you typically eat each day:________________

Please briefly describe your diet: ____

Dietary restrictions:____

Exercise (type, frequency):____

How many hours per night do you sleep?: _____________ Do you wake up feeling rested? ... NO/... YES

Occupation:____ Work Hours/Week:_________________

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day?______________

Caffeine (cups/day):__________ Nicotine (packs):__________ Alcohol (type, amount/week):_________

FAMILY HEALTH HISTORY

Mother:______________________________
Father:______________________________
Sister(s): ______________________________
Brother(s):______________________________
Daughter(s): ______________________________
Son(s):______________________________

Which of your blood relatives currently have or have had?

Cancer (type):____________________
Heart disease:____________________
Diabetes:____________________
Stroke:____________________
Hypertension (high blood pressure):__________
Thyroid problems:____________________
High cholesterol:____________________

REVIEW OF SYSTEMS

Emotional (please check those that apply to you):
...Mental tension ...Mood swings ...Nervousness ...Anxiety/worry
...Anger ...Irritability ...Frequent crying ...Fear
...Depression ...Restlessness ...Confusion ...Suicidal

Energy & Immunity (please check those that apply to you):
...Fatigue ...Slow Wound Healing ...Chronic Infections ...Chronic Fatigue Syndrome

Eye, Ear, Nose & Throat (please check those that apply to you):
...Impaired Vision ...Impaired Hearing ...Hay Fever ...Eye Pain/Strain
...Ear Ringing ...Teeth Grinding ...Glaucoma ...Glasses/Contacts
...Tearing/Dryness ...Earaches ...Sinus Problems ...Nose Bleeds
...Frequent Sore Throats

Respiratory (please check those that apply to you):
...Pneumonia ...Difficulty Breathing ...Persistent Cough ...Pleurisy ...Emphysema
...Asthma ...Frequent Common Colds ...Shortness of Breath Other Respiratory
Problems:______________________________

Cardiovascular (please check those that apply to you):
...Heart Disease ...Chest Pain ...Varicose Veins ...Rheumatic Fever
...Swelling Ankles ...Stroke ...High Blood Pressure ...Palpitations/Fluttering Heart Murmurs
Other Cardiovascular Problems:______________________________

Gastrointestinal (please check those that apply to you):
...Ulcers ...Passing Gas ...Liver Disease ...Changes in Appetite
...Heartburn ...Hemorrhoids ...Nausea/Vomiting ...Abdominal Pain
...Hepatitis B or C ...Epigastric Pain ...Gallbladder Disease ...Belching

Genito-Urinary Tract (please check those that apply to you):
...Kidney Disease ...Kidney Stones ...Painful Urination ...Impaired Urination
...Blood in Urine ..Frequent Bladder Infections ...Frequent Urination

Female Reproductive (please check those that apply to you):
...Heavy Flow ...PMS ...Nipple Discharge ...Clotting ...Vaginal Discharge
...Painful Periods ...Menopausal Symptoms ...Difficulty Conceiving ...Breast Lumps
...Irregular Cycles ...Bleeding Between Cycles

Menstrual/Birth History:
Age of First Menses: ______ # of Days of Menses: ______ Length of Cycle: _______
# of Pregnancies: ________ # of Abortions: _______ # of Miscarriages: ______ # of Live Births:______
Birth Control Type: ___________________________

Male Reproductive (please check those that apply to you):
...Sexual Difficulties ...Prostate Problems ...Testicular Pain/Swelling ...Penile Discharge

Musculoskeletal (please check those that apply to you):
...Neck/Shoulder Pain ...Muscle Spasms/Cramps ...Pain Mid Back Pain ...Lower Back Pain
...Leg Pain ...Arm Pain ...Upper Back ...Joint Pain (if so, where?):

Neurologic (please check those that apply to you):
...Vertigo/Dizziness ...Paralysis ...Numbness/Tingling ...Seizures/Epilepsy ...Loss of Balance

Any other information about your health you would like to add: _________________________________

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FINANCIAL GUIDELINES

Thank you for visiting us! Our clinic is dedicated to providing you with the finest quality in wellness care with the best service possible. Our Financial Guideline is based on an open and honest discussion of our fees. Please initial each statement and then sign at the bottom. A copy of this document will be provided to you.

Payment

Payment in full is due and appreciated at the time that services are rendered. We accept Cash, Checks, Visa and MasterCard. A credit card must be left on file via the clinic's secured service to be charged for any missed visit fees or unpaid insurance claims. _____

Insurance

As a service to our patients with insurance, we will bill the insurance company for you. Your insurance policy is a contract between you and your insurance company and, as a provider, we are not a part of that agreement. **Therefore, if your insurance company does not pay as expected, or delays payment beyond 90 days, you are responsible for the balance.** If your insurance company adjusts our fees, the resulting balance will be your responsibility. As a courtesy to you, we will collect your estimated patient's portion at the time of your visit and bill your insurance company for the balance. If your exact coverage is unclear at the time of your appointment, you will be charged the full cash rate and reimbursed as necessary once we verify your coverage. ____

Minors

Payment for the treatment of minors is the responsibility of the adult accompanying the minor. ____

Missed Appointments

We appreciate your respect for the appointment time that is reserved for you. **If you choose to cancel or reschedule your appointment with less than 48 hours notice, or if you fail to appear for your appointment, you will be charged a missed appointment fee of $190 for initial visit and $125 for follow up. ____**

Finance Charges

An interest charge of 1.5% per month (18% annually) will be applied to your account if it is over 90 days past due. A charge of $25 will be applied for returned checks.

I, (name)________________________________ , understand and agree to these Financial Guidelines, as of

(date) ______________________.

____

Signature of patient or guardian

____

Telephone number