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 our global community and receive free insights from Dr. Setareh & Salvador?
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):_____ Hypertension (high blood pressure):_____
Heart disease:_____ Thyroid problems:_____
Diabetes:_____ High cholesterol:_____
Stroke:_____

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 24 hours notice, or if you fail to appear for your appointment, you will be charged a missed appointment fee of $135 for initial visit and $100 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