Rose Palma, Licensed Acupuncturist

Rigpa Wellness

213-215-5479 | *rosep@rigpawellness.com*

Patient Name: _____

Address: _____

City/State/Zip: _____

Occupation: _____

Employer: _____

Employer Address: _____

_____

Employer Phone: _____

Spouse's Name: _____

Spouse's DOB: _____

Spouse's Occupation: _____

Spouse's Employer: _____

Whom may we thank for referring you?

_____

SSN: _____

Marital Status: _____
(single, married, DP, separate, widowed, divorced)

Gender Identity: _____
(male/female/nonbinary/genderfluid/etc)

Preferred Pronouns: _____
(he/she/they/etc)

DOB/Birthplace: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Best time and place to reach you:
_____

Email address:
_____

Age: _____ Weight: _____ Height: _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient: _____

Insurance Co.: _____ Group No.: _____

Is Patient covered by additional insurance? Yes No

Subscriber's Name: _____ Subscriber's DOB: _____ SS#: _____

Subscriber's Relationship to Patient: _____

Insurance Co.: _____

Patient's Name: _____

Today's Date: _____

IN CASE OF EMERGENCY

Contact/Relationship: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Family Physician:
_____

Phone No.:
_____

PATIENT CONDITION:

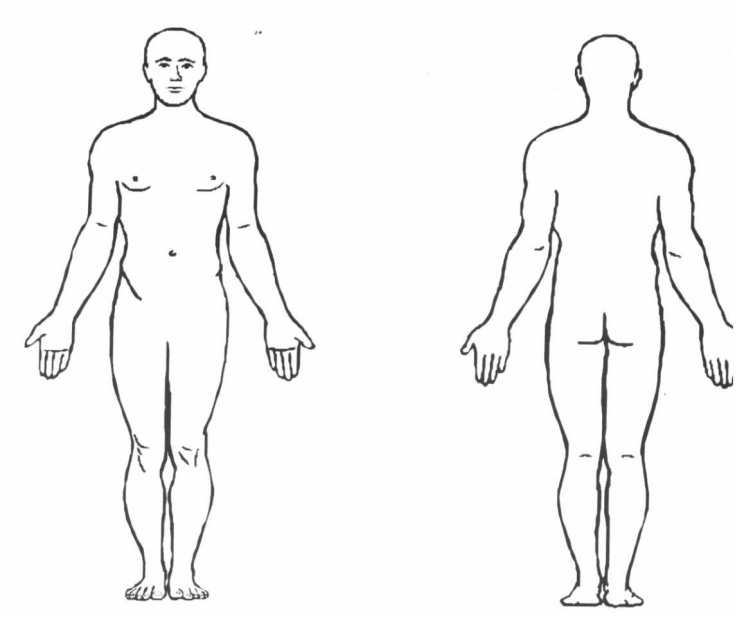
Your reason for this Visit: _____

_____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Not Sure

Mark an X on the picture where you continue to have pain, numbness, or tingling:



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____

Type of Pain:
☐ Sharp ☐ Dull
☐ Throbbing ☐ Shooting ☐ Burning
☐ Numbness ☐ Aching ☐ Swelling
☐ Tingling ☐ Cramps ☐ Stiffness
☐ Other: _____

How often do you have the symptoms?
____ Times per ☐ Day ☐ Week ☐ Month

☐ Constantly ☐ Frequently
☐ Intermittently ☐ Occasionally

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Other: _____

_____

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Activities or movements that are painful to perform: ☐ Sitting ☐ Standing

☐ Walking ☐ Bending ☐ Lying Down ☐ Other: _____

What treatment have you already tried for this condition?

☐ None ☐ MD (Allopathic/Western Medicine) ☐ Surgery ☐ Medications

☐ Chiropractic ☐ Injections ☐ Physical Therapy ☐ Naturopathic

☐ Other: _____

Name and phone of other practitioners who have treated you for your condition:

_____

_____

DATE OF LAST:

Physical Exam: _____ Spinal X-Ray: _____

Blood Test: _____ Chest X-Ray: _____

Urine Test: _____ Dental X-Ray: _____

Spinal Exam: _____ MRI/CT-Scan: _____

Have you had Chinese Medicine before? _____

Age: _____ HT: _____ WT: _____

FAMILY MEDICAL HISTORY:

☐ Allergies ☐ Asthma ☐ Arteriosclerosis ☐ Heart Disease

☐ Cancer ☐ Stroke ☐ Diabetes ☐ High Blood Pressure

☐ Seizures ☐ Dementia ☐ Alzheimer's

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Today's Date: _____

YOUR PAST MEDICAL HISTORY (Please check any that apply)

☐ Aids/HIV	☐ Alcoholism	☐ Appendicitis	☐ Arteriosclerosis
☐ Cancer	☐ Chicken Pox	☐ Diabetes	☐ Polio
☐ Hepatitis	☐ Herpes	☐ Measles	☐ High Blood Pressure
☐ Mumps	☐ Pacemaker	☐ Venereal Disease	☐ Multiple Sclerosis
☐ Scarlet Fever	☐ Stroke	☐ Surgeries	☐ Thyroid Disorders
☐ Tuberculosis	☐ Typhoid Fever	☐ Goiter	☐ Rheumatic Fever
☐ Gout	☐ Ulcer	☐ Whooping Cough	☐ Attempted Suicide

☐ Pregnant at this time ☐ Presently seeing a therapist

GAN (Please check any that apply)

☐ Depression	☐ Seizures	☐ Tremors	☐ Anger
☐ Dizziness	☐ Numbness	☐ Dry Eyes	☐ Headaches
☐ Cataracts	☐ Rib/Flack Pain	☐ Red Eyes	☐ Excessive Tearing
☐ Tinnitus	☐ Blurry vision	☐ Tics	☐ Excessive sighing
☐ Glaucoma	☐ Stroke	☐ Spots in the eyes	☐ Constant irritability

☐ Withered and brittle nails ☐ Feeling of tightness in chest ☐ Feeling of lump in throat

GYNOCOLOGICAL (Please check any that apply)

Length of Period: _____ Days

Length of Cycle: _____ Days

Flow: ☐ Heavy ☐ Light

Color: ☐ Normal ☐ Pale ☐ Bright Red

Date of Last Period: _____

Date and result of last Pap Smear: _____

Age when Menstruation began: _____

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Patient's Name: _____

Today's Date: _____

I experience:

☐ Clots ☐ Breast Tenderness ☐ Uterine Fibroids

☐ PMS ☐ Amenorrhea ☐ Vaginal Odor

☐ Cramps ☐ Breast Lumps ☐ Pain relieved by passing Clots

☐ Irregular Menstruation

Number of Pregnancies _____ Number of Premature Birth _____

Number of Live Births _____ Number of Miscarriages _____

Number of Abortions _____

PI (Please check any that apply)

☐ Fatigue ☐ Loss of appetite ☐ Loose stools ☐ Flatulence

☐ Bloating ☐ Prolapse ☐ Edema ☐ Muscle weakness

☐ Diarrhea ☐ Heavy Limbs ☐ Worry ☐ Abdominal Pain

☐ Hemorrhoids ☐ Excessive saliva ☐ Bleed or bruise easily ☐ Lack of taste

☐ Cloudiness of the head in morning ☐ Vaginal Discharge (Yellow or White)

XIN (Please check any that apply)

☐ Palpitations ☐ Anxiety ☐ Insomnia ☐ Phobias

☐ Tachycardia ☐ Stuttering ☐ Aphasia ☐ Incessant talking

☐ Red face ☐ Chest pain ☐ Heart disease ☐ Fainting

☐ Bitter taste in the morning ☐ Dream disturbed sleep ☐ Excessive dreaming

☐ Mouth and tongue sores ☐ Inappropriate laughter ☐ Irregular heartbeat

☐ Shortness of breath ☐ Easily startled

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Patient's Name: _____

Today's Date: _____

SHEN (Please check any that apply)

- ☐ Lower back pain
- ☐ Frequent Urination
- ☐ Edema
- ☐ Brittle Bones
- ☐ Teeth problems
- ☐ Nocturnal Emissions
- ☐ Infertility
- ☐ Memory problems
- ☐ Incontinence
- ☐ Arthritis
- ☐ Bedwetting
- ☐ Premature Ejaculation
- ☐ Hot Flashes
- ☐ Black circle under eyes
- ☐ Hearing problem
- ☐ Increased Libido
- ☐ Weakness of knees or ankles
- ☐ Decreased Libido
- ☐ Impotence
- ☐ Concentration problems
- ☐ Chronic sore throat
- ☐ Night sweats low grade fever in morning or afternoon

FEI (Please check any that apply)

- ☐ Acute cough
- ☐ Chronic cough
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Pneumonia
- ☐ Sore throat
- ☐ Weak Voice
- ☐ Spontaneous Sweating
- ☐ Frequent colds
- ☐ Loss of smell
- ☐ Emphysema
- ☐ Yellow phlegm
- ☐ White phlegm
- ☐ Wheezing
- ☐ Pleurisy
- ☐ Excessive grief of sadness
- ☐ Fullness in the chest
- ☐ Difficulty breathing while lying down
- ☐ Sinus problems
- ☐ Bleeding from nose

WEI (Please check any that apply)

- ☐ Hiccup
- ☐ Nausea
- ☐ Vomiting
- ☐ Excessive appetite
- ☐ Epigastric pain
- ☐ Acid reflux
- ☐ Loss of appetite
- ☐ Constipation
- ☐ Bleeding gums
- ☐ Belching
- ☐ Bad breath
- ☐ Swelling or pain in gums
- ☐ Tiredness in morning
- ☐ Vomiting of clear fluid

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Patient's Name: _____

Today's Date: _____

DAN (Please check any that apply)

☐ Bitter taste ☐ Timidity ☐ Indecisiveness ☐ Yellow complexion

☐ Stiff Neck ☐ Fatty stools ☐ Ear Infection ☐ Lack of Initiative

DA CHENG (Please check any that apply)

☐ Constipation ☐ Diarrhea ☐ Black stools ☐ Tenesmus

☐ Itchy anus ☐ Blood in stool ☐ Unable to hold urine ☐ Incomplete urination

☐ Wake up to urinate often ☐ Bladder or kidney stones

LIST ANY INJURIES AND/OR SURGERIES YOU'VE HAD: DATE:

Falls _____ _____
Head Injuries _____ _____
Broken Bones _____ _____
Dislocations _____ _____
Surgeries _____ _____

EXERCISE:

☐ None ☐ Moderate ☐ Daily ☐ Heavy

WORK ACTIVITY: ☐ Sitting ☐ Standing

☐ Light Labor ☐ Heavy Labor

HABITS:

☐ Alcohol _____ Drinks/Week

☐ Smoking _____ Packs/Day

☐ Marijuana _____ How many times daily

☐ High Stress _____ Reason

LIST ALLERGIES:

_____

_____

_____

_____

VITAMINES, MINERALS, HERBS & TEAS:

_____

_____

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MEDICATIONS	START	DURATION
☐ Digitalis _____	_____	_____
☐ Inderal _____	_____	_____
☐ Nitroglycerin _____	_____	_____
☐ Insulin _____	_____	_____
☐ Steroid _____	_____	_____
☐ Tranquilizer _____	_____	_____
☐ Narcotic Analgesics _____	_____	_____
☐ Antibiotics _____	_____	_____
☐ Barbiturates _____	_____	_____
☐ Muscular relaxants _____	_____	_____
☐ Antihistamine _____	_____	_____
☐ Others _____	_____	_____

I certify that the information on this 8-page form is complete and accurate to the best of my knowledge. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage.

Patient Signature: Date:

_____ _____

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RESTRICTED MEDICAL HISTORY

The following medical history information has additional restrictions placed upon its release to third parties, and will not be disclosed to others unless you explicitly authorize it or we are otherwise ordered by legal authorities to release it:

Please check any of the following conditions you currently have, or have had in the past:

ADDICTIONS: ☐ Yes ☐ No

If yes, to what substance? _____

If you have stopped using this, when did you stop? _____

AID/HIV: ☐ Yes ☐ No
If yes, please give date of first diagnosis _____ and date of most recent lab work _____

ALCOHOLISM: ☐ Yes ☐ No

BULIMIA: ☐ Yes ☐ No

MENTAL HEALTH DISORDER: ☐ Yes ☐ No
If yes, please describe: _____

SUICIDE ATTEMPT: ☐ Yes ☐ No
If yes, how long ago? _____

Sexually Transmitted Disease(s): ☐ Yes ☐ No
If yes, please indicate which ones and when they occurred _____

☐ Chlamydia ☐ Genital Warts ☐ HPV ☐ Gonorrhea ☐ Genital Herpes

☐ NGU ☐ Syphilis ☐ Other

DOMESTIC VIOLENCE OR ABUSE VICTIM: ☐ Yes ☐ No

Patient's Name: _____

Today's Date: _____

ACUPUNCTURIST'S NOTE REGARDING INFORMATION ON THIS PAGE

(please leave the section below blank for your acupuncturist to fill out; these notes will also be restricted.)

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