Anna Hsieh Gold, L.Ac, MTOM, RYT
Acupuncture and Herbal Medicine
www.annagoldacupuncture.com
415.891.9993

Health History Questionnaire

Name: ______________________________ Date ____________

Address: ______________________________

Home Phone ______________ Cell Phone ______________

Work Phone ______________ Email: ______________

Social Security Number _______-_______-_______ Sex: ☐Female ☐Male

Height: __________ Weight: __________ Date of Birth: __________ Age: ______

Occupation: ______________ Employer ______________

Emergency Contact's Name and Number: ______________

Who can I thank for your referral? Name ______________

Add to our newsletter? (We only send important news and specials 3 times a year) ☐Yes ☐No

Are you under the care of a physician now? ☐Yes ☐No

If yes, for what ?______________

Physician's Name and Number ______________

Does your health insurance cover acupuncture? If yes, please fill in next section, if not skip it.

Insurance name: ______________ Group ID: ______________

Subscriber ID ______________ Insurance Phone ______________

Major Complaint/Health Problem:

____

____

How did this condition develop?

____

____

Is there anything that makes it worse?

____

Is there anything that makes it better?

____

Have you ever received treatment for this condition? ________ If yes, when? ____________

By Whom? ______________ Type of treatment? ______________

What was the diagnosis?

____

What were the results of treatment?

____

To what extent does the problem interfere with your daily activity (work, exercise, sleep, sex,?)

____

____

Personal Medical History – please note dates:

☐ Allergies ________	☐ Heart disease ________	☐ Seizures ________
☐ Asthma ________	☐ Hepatitis ________	☐ Stroke ________
☐ Cancer ________	☐ High blood pressure ________	☐ STDs ________
☐ Diabetes ________	☐ HIV/AIDS ________	☐ Thyroid disease ________

Family Medical History – please note relationship:

☐ Allergies ________	☐ Heart disease ________	☐ Seizures ________
☐ Asthma ________	☐ Hepatitis ________	☐ Stroke ________
☐ Cancer ________	☐ High blood pressure ________	☐ Mental ________
☐ Diabetes ________	☐ Drug/alcohol abuse ________	☐ Thyroid disease ________

Medications

What medications are you taking? Please include prescription name, reason, and dosage.

____

____

What vitamin supplements are you taking? How much?

____

____

Surgeries (types & dates):

____

____

Significant Traumas:

____

____

Allergies (drugs, chemicals, foods, etc.)

____

Occupational Stress (chemical, physical, psychological)

____

Habits

Do you have a regular exercise program?

Type: ________________________________ Frequency: __________________________

Are you or have you been on a restricted diet? What kind and why?

____

Please indicate usage per day or per week:

Cigarettes ______________	per ______		Tea ______________	per ________
Alcohol ______________	per ______		Soft Drinks ___________	per ________
Drugs ______________	per ______		Sugar ______________	per ________
Coffee ______________	per ______		Other ______________	per ________

Please describe your average daily diet:

Morning: ____

Afternoon: ____

Evening: ____

Do you suffer from any of the following?

Check all that apply, and for each note if it is current or past.

General

- ☐Recurrent Infections
- ☐Night Sweats
- ☐Sweat easily
- ☐Bleed or bruise easily
- ☐Strong thirst (prefer hot or cold?)
- ☐Thirst with no desire to drink
- ☐Fatigue
- ☐Sudden energy drops
  - Time of day____________
- ☐Poor Sleep
- ☐Tremors
- ☐Poor Balance
- ☐Edema
- ☐Dizziness
- ☐Recurrent sore throat
- ☐Underweight
- ☐ Overweight

Skin

- ☐Rashes
- ☐Itching
- ☐Psoriasis
- ☐Pimples
- ☐Dry skin / scalp
- ☐Recent moles
- ☐Changes in hair/skin
- ☐Eczema
- ☐Other ___________

Head/Eyes/Ears/Nose/Throat

- ☐Headaches
  - Where _________
  - When _________
- ☐Migraines
- ☐Discharge from ear
- ☐Poor hearing
- ☐Ringing in ears
- ☐ vision
- ☐Night blindness
- ☐Color blindness
- ☐Eye Pain
- ☐Excessive Tearing
- ☐Squint
- ☐Glasses: Age?
- ☐Sore eyes
- ☐Facial Pain
- ☐Nose bleeds
- ☐Nasal discharge
- ☐Blocked nose
- ☐Snoring
- ☐Grinding teeth
- ☐Teeth problems
- ☐Hoarseness
- ☐Tonsillitis
- ☐Swollen glands
- ☐Sores on lips/mouth
- ☐Spots in front of eyes
- ☐Other ____________

Cardiovascular
- ☐Pacemaker
- ☐High Blood Pressure
- ☐Low Blood Pressure
- ☐Chest discomfort/pain
- ☐Heart Palpitations
- ☐Cold hands or feet
- ☐Swelling of hands or feet
- ☐Blood Clots
- ☐Spider veins
- ☐Fainting
- ☐Other ____________
- ☐Changes in sex drive

Respiratory
- ☐Difficulty breathing
- ☐Pain with breathing
- ☐Shallow breathing
- ☐Shortness of breath
- ☐Production of phlegm
  color __________
- ☐Recurrent cough
- ☐Bronchitis
- ☐Pneumonia
- ☐Asthma/Wheezing
- ☐Status asthmaticus
- ☐Other __________

Digestion
- ☐Bad breath
- ☐Change in appetite
- ☐Nausea
- ☐Vomiting
- ☐Heartburn
- ☐Indigestion
- ☐Belching
- ☐Abdominal pain or cramps
- ☐Weight gain
- ☐Weight loss
- ☐Loose stools / Diarrhea
- ☐Strong smelling stools
- ☐Bloody stools
- ☐Pale stools
- ☐Green stools
- ☐Black stools
  (not daily, or difficult)
- ☐Pain with passing stools
- ☐Gas
- ☐Rectal pain
- ☐Hemorrhoids
- ☐Bulimia
- ☐Anorexia

Genitourinary
- ☐Pain on urination
- ☐Urgency with urination
- ☐Frequent urination
- ☐Blood in urine
- ☐Decrease in urinary flow
- ☐Unable to hold urine
- ☐Incontinence at night
- ☐Dribbling urination
- ☐Kidney stones
- ☐Prostate problems
- ☐Impotency
- ☐Hernia
- ☐Rashes
- ☐Do you wake at night to urinate?
  How many times? __________
- ☐Other _____________

Gynecological
- # of pregnancies___________
- # births____________________
- # miscarriages_____________
- # abortions_________________
- Age of 1st menses____________
- # days between menses______
- Duration of menses__________
- 1st day of last menses________
- Age of menopause___________
- Date of last PAP____________
- Are you pregnant now?_______
- ☐PMS
- ☐Irregular periods
- ☐Painful periods
- ☐Light periods
- ☐Heavy periods
- ☐Clots
- ☐Fibroids
- ☐Endometriosis
- ☐Infertility
- ☐Vaginal discharge
- ☐Vaginal sores
- ☐Postcoital bleeding
- ☐Breast lumps
- ☐Nipple discharge

Musculoskeletal
- ☐Neck ache/pain
- ☐Back ache/pain
- ☐Knee ache/pain
- ☐Shoulder pain
- ☐Elbow/Forearm pain
- ☐Hand/Wrist pain
- ☐Foot/Ankle pain
- ☐Joint/Bone problems
- ☐Torn tissues
- ☐Prostheses
- ☐Muscle pain
- ☐Other___________

Neurological
- ☐Seizures
- ☐Nerve damage
- ☐Paralysis
- ☐Stroke
- ☐Sleep disorder
- ☐Concussion
- ☐Vertigo
- ☐Lack of coordination
- ☐Loss of balance
- ☐Poor memory
- ☐Difficult concentrating
- ☐Other _______

Behavioral
- ☐Vacant
- ☐Moody
- ☐Susceptible to stress
- ☐Aggressive/Bad temper
- ☐Overly emotional
- ☐Anxiety
- ☐Panic Attack
- ☐Depression
- ☐Fear
- ☐Substance abuse
- ☐Other _________

Have you ever been treated for emotional problems? __

Have you ever attempted suicide?

____

Please note the severity of your problem right now:

0 1 2 3 4 5 6 7 8 9 10

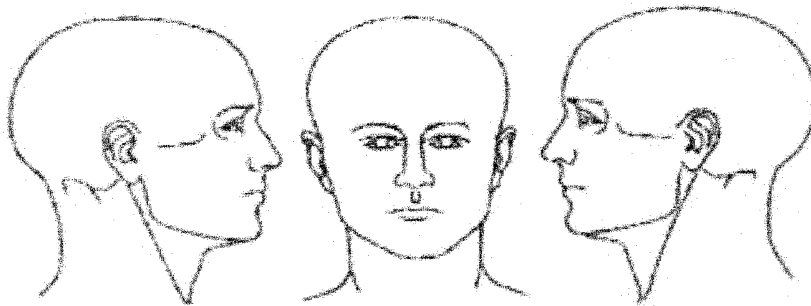
No Problem | Worst Imaginable

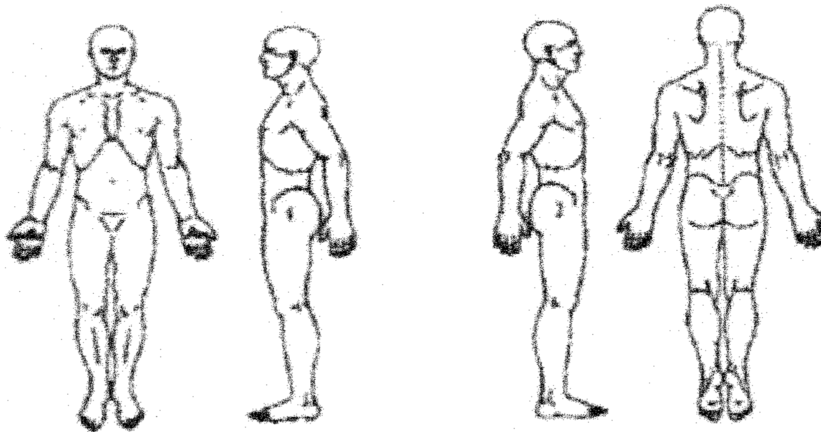
Please note the greatest degree of severity of your problem within the last week:

0 1 2 3 4 5 6 7 8 9 10

No Problem | Worst Imaginable

Please indicate areas of pain or distress:





Comments:____

I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

Name ____

Signature___________________________ Date ________________

Anna Hsieh Gold, L.Ac, MTOM, FABORM
500 Sutter Street, Suite 908, San Francisco, CA 94102

www.annagoldacupuncture.com
office: 415.891.9993

Informed Consent to Care and Treatment

I hereby request and consent to the performance of acupuncture treatments and other Eastern Medicine procedures, including various physical modalities, on me by Anna Hsieh Gold, L.Ac.

I understand that methods of treatment may include, but are not limited to, acupuncture, infrared therapy, electrical stimulation, massage, herbal medicine and nutritional counseling. I have had the opportunity to discuss with the treating physician or other clinic personnel the nature and purpose of acupuncture treatments and other procedures.

I have been informed that acupuncture is a generally safe method of treatment, but as with all medical procedures, it may have some side effects, most commonly bruising, and less frequently numbness or tingling near the needle sites that may last a few days. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Eastern medicine, although some may be toxic in large doses. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of herbs or nutritional supplements. I understand that some herbs or supplements may be inappropriate during pregnancy. I will notify Anna Hsieh Gold, L.Ac if I am or become pregnant.

I understand that results are not guaranteed.

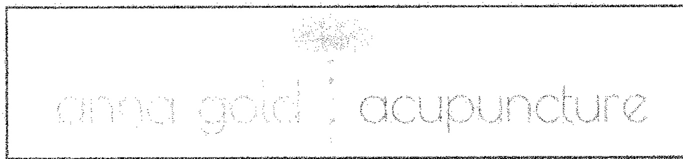
I have read, or have had read to me, the above consent to care and treatment. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

____

Patient name (printed)

____

Patient signature   Date



Anna Hsieh Gold, L.Ac, MTOM, FABORM
500 Sutter Street, Suite 908, San Francisco, CA 94102

www.annagoldacupucture.com
office: 415.891.9993

Cancellation policy

Kindly give us notice of any appointment changes at least 24 hours prior to your appointment. This gives us time to make that slot available to another patient. You will receive an email reminder 48 hours in advance of your appointment. Late cancellations and missed appointments are charged a fee of $100. If you are using insurance benefits, note that you will be responsible for $100 cancellation fee. Insurance will not pay for missed appointments.

Late arrivals

If you arrive more than 15 minutes past your appointment time, we will do our best to accommodate you. However, if taking you in late will cause delays for the rest of our patients for that day, we will reschedule you. This counts as a missed appointment and the charge is $100.

I have read and agree to the above policies.

Name:____

Signature:________________________Date: ________________

Anna Hsieh Gold, L.Ac, MTOM, FABORM
500 Sutter Street, Suite 908, San Francisco, CA 94102

www.annagoldacupucture.com
office: 415.891.9993

Insurance Agreement & Assignment of Benefits

Please Read Carefully and Sign Below:

I authorize the release of any medical or other information necessary to process claims submitted to my insurance company or the other responsible party. I also assign the payment of medical benefits directly to Anna Hsieh Gold, L.Ac, PC for services provided. I understand that I am fully responsible for my bill and that if attempts to collect payment from my insurance company/responsible party are not successful, I will remit the balance due upon notification. Co-payments and deductibles are due at time of service. I understand if care is discontinued, the balance for care received up to that date is due in full in 30 days.

A Note About Insurance:

Verification of insurance does not guarantee coverage of acupuncture benefits. A description of benefits is not an authorization or guarantee of payments. You are financially responsible for all services/treatments rendered at Anna Hsieh Gold, L.Ac, PC when your insurance denies coverage. Your insurance company may deny coverage for certain diagnoses or dates of service. We advise that you become fully aware of your insurance benefits and are proactive in communicating directly with your insurance company when this occurs.

Credit Card on File:

We require a credit card on file for all insurance patients. As a very small business, we are limited in our ability to manage ongoing patient accounts of balances due. We will make every effort to collect payment from your insurance carrier, including appealing claims that have been denied. If we are ultimately unable to collect payment from your insurance carrier, then we will notify you of the balance due. Payment is due within 30 days, at which time we will bill your

I clearly understand and agree that all services rendered me are charged to me.

Patient Name: ____

Patient Signature: ______________________ Date _____/_____/ ______

Anna Hsieh Gold, L.Ac, MTOM, FABORM
500 Sutter Street, Suite 908, San Francisco, CA 94102

www.annagoldacupucture.com
office: 415.891.9993

Having a credit card on file allows us to provide you with the following services:

Following a request via email or phone:

- o Drop ship supplements, herbs, or lab kits directly to your home
- o Place custom orders for you
- o Provide you with lab slips
- o Charge for missed appointments

Billing your insurance directly for you

Credit Card Authorization

I grant authorization to Anna Hsieh Gold, L.Ac, PC to bill the following credit card:

Name on Credit Card:____

Circle one: Visa MasterCard American Express

Card # : ____

Expiration Date: ____________________ CVV Code:_____________________

Cardholder's signature:____

Today's Date:_________________________