Kamron Jafari, L.Ac., Acupuncture Clinic
(424) 341-1989

Patient Confidential Information

(Please Print)

Patient's First Name:	Last:	Middle:	Marital status (circle one)
			Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:			Home phone no.: ( )
City:	State:	ZIP Code:	Cell phone no.: ( )
Occupation:	Employer:		Work phone no.: ( )
Employer's Address:			Personal E-mail:
			Social Security no.:
Referred by:			Driver's License:

Appointment Reminder by: ❑ Phone Call ❑ Email ❑ Text Message

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Name of Primary Insurance:	Policy no.:	Group no.:	Insurance phone no.: ( )
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /
Patient's relationship to subscriber:	❑ Self ❑ Spouse	❑ Child ❑ Other	
Name of Secondary Insurance:	Policy no.:	Group no.:	Insurance phone no.: ( )
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /
Patient's relationship to subscriber:	❑ Self ❑ Spouse	❑ Child ❑ Other	

EMERGENCY CONTACT INFORMATION

Name of local friend or relative:		Relationship to patient:
Home phone no.: ( )	Work phone no.: ( )	Cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the health provider. I understand that I am financially reponsible for any balance. I also authorize Jafari Acupuncture Clinic or insurance company to release any information required to process my claims.

Patient's Signature (Parent/Guardian signature if patient is a minor) Date

TERMS AND CONDITIONS OF SERVICE

ADMISSION AND MEDICAL SERVICES AGREEMENT

The patient or the patient's representative consents to the admission of the patient to Kamron Jafari, L.Ac. if this is deemed necessary for the care of the patient. All terms and conditions hereof shall also apply to such conditions.

MEDICAL CONSENT

I have read and fully understand and consent to any Oriental Medicine treatments or procedures that are given by Kamron Jafari, L.Ac. The patient accepts the full responsibility to follow up the medical advice given by Kamron Jafari, L.Ac. The patient or the patient's representative consents to the treatment procedures and its results and repercussion thereof and accepts arbitration if deemed necessary.

TREATMENT OF MINORS

During the treatment of patients under 18 years of age, the patient's legal guardian must be present in the clinic during the entire session for each treatment.

RELEASE OF INFORMATION

Kamron Jafari, L.Ac. will, only through a patient completing a specific and separate Authorization for Release of Information form, or in compliance with a legal subpoena, furnish from the patient's record necessary information to the referring physician, if any, and to others to the extent required in connection with a claim for aid, insurance, or medical assistance to which the patient may be entitled.

CONFIDENTIALITY AND PRIVACY PRACTICES

As a health care provider, Kamron Jafari, L.Ac. is required by law to maintain and protect the confidentiality of your health information. The patient must give us written consent to waive this confidentiality. Exceptions to this rule are strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, law enforcement activities, obtaining payment from third-party payers, and in consultation with other healthcare professionals. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. Your rights to privacy regarding your protected health information: 1) You may request restrictions on your disclosures, 2) You may inspect and receive copies of your records within 30 days with a request, 3) You may request to view changes to your records. A more complete description of our privacy practices can be requested.

FINANCIAL AGREEMENT

The patient or patient's representative shall pay Kamron Jafari, L.Ac. for services rendered in accordance with the regular rates and terms of Kamron Jafari, L.Ac. When this agreement is executed by the patient, the patient's representative or a financial guarantor, all shall be jointly and individually liable for the patient. Should accounts be referred to an attorney or collection agency, reasonable attorney's fees and collection expenses incurred shall be payable in addition to the other amounts due.

MISSED APPOINTMENTS & CANCELLATION POLICY

Your appointments are very important to us. Time allocated for an appointment is reserved especially for YOU. We do understand that sometimes schedule adjustments are necessary; therefore, we respectfully request at least 24 hours notice for adjustments to your appointments and for cancellations. All our policies are designed to benefit our patients and provided in the best quality and tradition of excellent servicing for our established and future clientele.

Please understand that when you forget or cancel your appointment without sufficient notice, we miss the opportunity to fill that appointment time for clients on our waiting list who may need our services.

Notification given at least 24 hours prior to your appointment will receive no charges.

Notification given less than 24 hours prior to appointment time, or failure to show up on time for your appointment, will result in a flat rate charge of $75.

CONFIRMATION PHONE-CALLS OR EMAILS

We do understand how easy it may be to forget an appointment, therefore all appointments are confirmed 48 hours prior via phone-call or email for your convenience. It remains your responsibility to remember your appointment dates and times to avoid late arrivals, missed appointments, and help us service our patients better by providing enough notice to avoid the cancellation fees. Please ensure that we have your current mobile phone number and email address on file.

ACKNOWLEDGEMENT AND AGREEMENT OF TERMS

Kamron Jafari, L.Ac. and the patient or patient's representative hereby enter into this agreement. The patient or the patient's representative certifies that he/she has read and accepted the "Terms and Conditions of Service."

Full payment is due at the time of your service. We accept cash, check and credit card.

Patient Signature_____ Date_____

Patient Representative_____ Date_____

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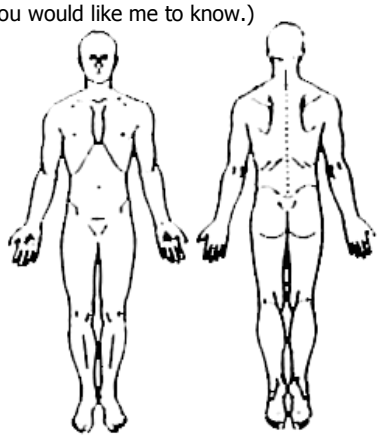
CASE HISTORY

(Please Print)

PATIENT INFORMATION

Main Complaint: (Please indicate when it started, diagnosis, symptoms and any other information you would like me to know.)



Have you seen any other doctor about this condition? ❑ Yes ❑ No	If yes, when?	Physician's name:

Other Complaint(s): (Please indicate when it started, diagnosis, symptoms and any other information you would like me to know.)

Have you seen any other doctor about this condition? ❑ Yes ❑ No	If yes, when?	Physician's name:

PHYSICIAN INFORMATION

Primary Physician's name:		Phone no.: ( )	Date of last physical: / /
Street address:	City:	State:	ZIP Code:
Other treating medical professional's name:	Type/Specialty:	Phone no.: ( )	Date of last exam: / /
Other treating medical professional's name:	Type/Specialty:	Phone no.: ( )	Date of last exam: / /
Other treating medical professional's name:	Type/Specialty:	Phone no.: ( )	Date of last exam: / /

Have you had acupuncture before? ❑ Yes ❑ No	If yes, for what condition?

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HEALTH HISTORY

(Please Print)

PATIENT INFORMATION

Significant Trauma: (physical or emotional)

Hospitalizations & Surgeries: (Date/Description/Place)

Medications: (Name/Dosage/Indicated for)

Vitamins/Supplements/Herbs: (Name/Dosage/Indicated for)

Allergies: (chemical, environmental, food, drugs, etc.)

Mark any that apply to you:

- ❑ Pacemaker
- ❑ Electric Implants
- ❑ Metal Implants
- ❑ Severe Bleeding Disorders
- ❑ Pregnant
- ❑ Cancer
- ❑ Thyroid Imbalance
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Stroke
- ❑ Heart Disease
- ❑ Low Blood Pressure
- ❑ High Blood Pressure
- ❑ HIV

FAMILY MEDICAL HISTORY

Complete for each family member. Place an X in the box indicating any illnesses they ever had.

	Self	Mother	Mother's Family	Father	Father's Family	Siblings
Allergies						
Anemia/Blood Dis						
Arthritis						
Asthma						
Cancer or Tumors						
Type						
Chemical Dependency						
Diabetes						
Glaucoma						
Heart Disease						
High Blood Pressure						
Kidney/Bladder Dis						
Mental Illness						
Migraines						
Seizures/Epilepsy						
Stomach/Intestinal Dis						
Stroke						
Thyroid Dis						
Tuberculosis						
Other						
Specify						
		Age:		Age:		Age:

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HEALTH HISTORY

(Please Print)

LIFESTYLE & DIET

Type of Diet: ❑ Standard American ❑ Low Fat ❑ Weight Loss ❑ Vegan ❑ Other (specify)
❑ Fast/Quick Prep ❑ Balanced Food Groups ❑ Low Carb ❑ Muscle Building ❑ Vegetarian

Meals:			Avg Time of Day	Description of Meal
Breakfast	❑ Yes	❑ No		
Snack	❑ Yes	❑ No		
Lunch	❑ Yes	❑ No		
Snack	❑ Yes	❑ No		
Dinner	❑ Yes	❑ No		
Snack	❑ Yes	❑ No		

			When Started	When Stopped	Amount (quantity, # of days, days per week)
Coffee	❑ Yes	❑ No			
Tea	❑ Yes	❑ No			
Soda	❑ Yes	❑ No			
Alcohol	❑ Yes	❑ No			
Tobacco	❑ Yes	❑ No			
Illegal Drugs	❑ Yes	❑ No			
Other	❑ Yes	❑ No			

Have you ever had an eating disorder? ❑ Yes ❑ No

Type: _____

Is Nutrition something you would like to improve? ❑ Yes ❑ No

Activity Level: (Mark the one that best applies to you.)

❑ Sedentary Job w/ No Exercise ❑ Moderate Job w/ No Exercise ❑ Active Job w/ No Exercise
❑ Sedentary Job w/ Some Exercise ❑ Moderate Job w/ Some Exercise ❑ Active Job w/ Some Exercise
❑ Sedentary Job w/ Much Exercise ❑ Moderate Job w/ Much Exercise ❑ Active Job w/ Much Exercise

Exercise:

Type of Activity	Length of time	Days per week

Would you like to improve or add to your exercise regimen? ❑ Yes ❑ No

Mood: (Do you experience any of the following often?)

❑ Depression ❑ Isolated ❑ Grief ❑ Irritable ❑ Anxiety ❑ Fear ❑ Nervousness
❑ Sadness ❑ Hopelessness ❑ Anger ❑ Mood Swings ❑ Insecurity ❑ Phobias ❑ Obsessive Thinking

Would you like to improve your mood? ❑ Yes ❑ No

Which of the following areas of life are you satisfied?

❑ Work ❑ Relationship ❑ Friends ❑ Family ❑ Spiritual Life ❑ Health ❑ Security

Sleep: (Average Time of Day) Go to Bed: _____ Wake Up: _____ Insomnia? ❑ Yes ❑ No

Would you like to improve your sleep quality? ❑ Yes ❑ No

Stress Level: ❑ High Stress ❑ Moderate Stress ❑ Mild Stress ❑ Periodic Stress ❑ Not Stressed

Would you like to handle stress better, or reduce the effects of stress? ❑ Yes ❑ No

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HEALTH HISTORY

(Please Check any that pertain to you)

SKIN & HAIR

❑ Dry Skin	❑ Nail problems	❑ Eczema	❑ Psoriasis	❑ Acne	❑ Recent moles	❑ Change in moles
❑ Itching	❑ Dandruff	❑ Hives	❑ Fungal infection	❑ Warts	❑ Skin discoloration	❑ Change in skin
❑ Rashes	❑ Loss of Hair		❑ Athlete's Foot	❑ Corns	❑ Open Sore	❑ Change in hair

HEAD, EYES, EARS, NOSE and THROAT

❑ Headache	❑ Dental problems	❑ Poor vision	❑ Cataracts	❑ Sinus problems	❑ Sore Throat
❑ Migraines	❑ Gum problems	❑ Eye Strain	❑ Glaucoma	❑ Nasal Congestion	❑ Hoarse Voice
❑ Concussion	❑ Mouth Sores	❑ Eye Pain	❑ Night Blindness	❑ Nose Bleeds	❑ Difficulty Swallowing
❑ Dizziness/Vertigo	❑ Sores on Lips	❑ Blurry Vision	❑ Color Blindness	❑ Polyps	❑ Poor Hearing
❑ Facial Pain	❑ Sores on Tongue	❑ Floaters/Spots	❑ Glasses/Contacts	❑ Deviated Septum	❑ Ringing in Ears
❑ TMJ	❑ Grinding Teeth	❑ Sudden Vision Change			❑ Earache
❑ Jaw Clicks/Locks					

RESPIRATORY (LU)

❑ Cough	❑ Phlegm	❑ Allergies	❑ Difficult Breathing	❑ Shortness of Breath	❑ Bronchitis
❑ Wheeze	❑ Tight Chest	❑ Sweat Easily	❑ Difficulty Inhaling	❑ Pain w/ Deep Breath	❑ Pneumonia
❑ Chills	❑ Asthma	❑ Catch Colds Frequently	❑ Difficulty Exhaling		❑ Emphysema
❑ Fever		❑ Coughing Blood	❑ Difficulty Breathing Lying Down		❑ Pleurisy

CARDIOVASCULAR (HT)

❑ Palpitations	❑ Insomnia	❑ Low Blood Pressure	❑ Coronary Heart Disease	❑ Mitral Stenosis
❑ Chest Pain/Pressure	❑ Difficulty falling asleep	❑ High Blood Pressure	❑ Rheumatic Heart Disease	❑ Mitral Prolapse
❑ Irregular Heart Beat	❑ Difficulty staying asleep	❑ Cold Hands/Feet	❑ Hardening of Arteries	❑ Myocarditis
❑ Fainting	❑ Blood Clots	❑ Swelling of Hands/Feet	❑ Varicose/Spider Veins	❑ Phlebitis

GASTROINTESTINAL (SP/ST, LI, LIV)

❑ Low Appetite	❑ Change in Appetite	❑ High Appetite	❑ Constipation	❑ Hemorrhoids	❑ Colitis
❑ Fatigue	❑ Weight Loss/Gain	❑ Strong Thirst	❑ Abdominal Pain	❑ Rectal Pain	❑ Crohn's Disease
❑ Bloating	❑ Bleed/Bruise Easily	❑ Nausea	❑ Acid Reflux/GERD	❑ Blood in Stool	❑ IBS
❑ Borborygmus	❑ Hernia	❑ Vomiting	❑ Belching	❑ Black/Tar Like Stools	❑ Rib Pain
❑ Gas	❑ Anemia	❑ Bad Breath	❑ Indigestion	❑ Chronic Laxative Use	❑ Jaundice
❑ Loose Stools	❑ Muscle Weakness	❑ Diarrhea	❑ Cravings	❑ Alternating Diarrhea & Constipation	

GENITO-URINARY (KD/UB)

❑ Painful Urination	❑ Unable to Hold Urine	❑ Decreased Libido	❑ Genital Itching	❑ Premature Ejaculation
❑ Frequent Urination	❑ Weak Urine Stream	❑ Increased Libido	❑ Abnormal Discharge	❑ Nocturnal Emission
❑ Urgent Urination	❑ Dribbling After Urination	❑ Kidney Stones	❑ Yeast Infection	❑ Prostate Problems
❑ Burning Urination	❑ Bed Wetting	❑ Urinary Tract Infection	❑ Genital Sores	❑ Prostatitis
❑ Blood in Urine	❑ Night Urination	❑ Bladder Infection	❑ Herpes	❑ Testicular Pain
❑ Cloudy Urine	❑ Scanty Urine	❑ Kidney Infection	❑ Venereal Disease	❑ Impotence
❑ Lower Back Pain	❑ Excessive Urine	❑ Edema		

NEUROPSYCHOLOGICAL

❑ Seizures	❑ Difficulty Concentrating	❑ Lack of Coordination	❑ Panic Attacks	❑ ADD/ADHD
❑ Tremors	❑ Poor Memory	❑ Loss of Balance	❑ Mood Swings	❑ Manic Depression
❑ Areas of Numbness			❑ Mood Disorder	❑ Seasonal Affective Disorder

Have you ever been treated for emotional problems? ❑ Yes ❑ No ❑ Alcoholism

Have you ever considered or attempted suicide? ❑ Yes ❑ No

Have you ever been treated for substance abuse? ❑ Yes ❑ No

INFECTION

❑ Measles	❑ Chicken Pox	❑ Malaria	❑ Rheumatic Fever	❑ Tuberculosis
❑ Mumps	❑ Small Pox	❑ Typhoid Fever	❑ Scarlet Fever	❑ Whooping Cough

OTHER

❑ Hot Flashes	❑ Night Sweats	❑ Osteoporosis

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HEALTH HISTORY

(Please Print)

GYNECOLOGICAL/REPRODUCTIVE

- ❑ Difficult/Painful Intercourse
- ❑ Vaginal Dryness
- ❑ Excess Vaginal Discharge
- ❑ Leucorrhea
- ❑ Painful Menstruation
- ❑ Menstrual Cramps
- ❑ Irregular Periods
- ❑ PMS
- ❑ Dark Menstrual Blood
- ❑ Light Menstrual Blood
- ❑ Excess Menstrual Blood
- ❑ Scanty Menstrual Blood
- ❑ Unusual Menstrual Blood
- ❑ Blood Clots
- ❑ Breast Lump(s)
- ❑ Fibrocystic Breasts
- ❑ Uterine Fibroids
- ❑ Ovarian Cysts
- ❑ Polycystic Ovarian Disease
- ❑ Endometriosis

_____ Number of Pregnancies
_____ Number of Ectopic Pregnancies
_____ Number of Births
_____ Number of Abortions
_____ Number of Miscarriages

_____ Age at 1st Menstruation
_____ Number of Days Between Periods
_____ Number of Days of Period
_____ First Day of Last Period
_____ Date of Last PAP/Pelvic

❑ Use of Birth Control
Type: _____

How Long: _____

Previous Pregnancies:

Year	Length	Labor Hours	Type of Delivery	Complications