INITIAL HEALTH STATUS

COSTA ACUPUNCTURE
11819 Wilshire Blvd, Los Angeles, CA 90025
(310) 914-9700

Patient Name _____ Age _____ Birthdate _____ Sex M F
Last First
Address _____ City State Zip _____
Phone _____ Email _____
Employer _____ Occupation _____
Subscriber Name _____ Subscriber ID # _____ Group # _____
Primary Health Plan _____ Patient/Member ID # _____
2nd Health Plan _____ Primary Care Physician (PCP) _____ PCP Phone _____
(Required) (Required)
Are you under the care of a physician? ☐ No ☐ Yes, for what conditions? _____
Please describe your current health problem(s) _____
How and When it began _____ Is this work related? Y N
What treatment have you received for the above condition(s)? ☐ Surgery ☐ Medications ☐ Physical Therapy
☐ Injections ☐ Chiropractic ☐ Massage ☐ Other _____
Please describe your progress: ☐ Worse ☐ No Change ☐ 25% Better ☐ 50% Better ☐ 75% Better or _____

Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other _____

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

In the past week, how much has your pain interfered with your daily activities?

No Interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally
Describe your current health condition: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

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Please check all of the following that apply to you and list any medication(s) you are taking:

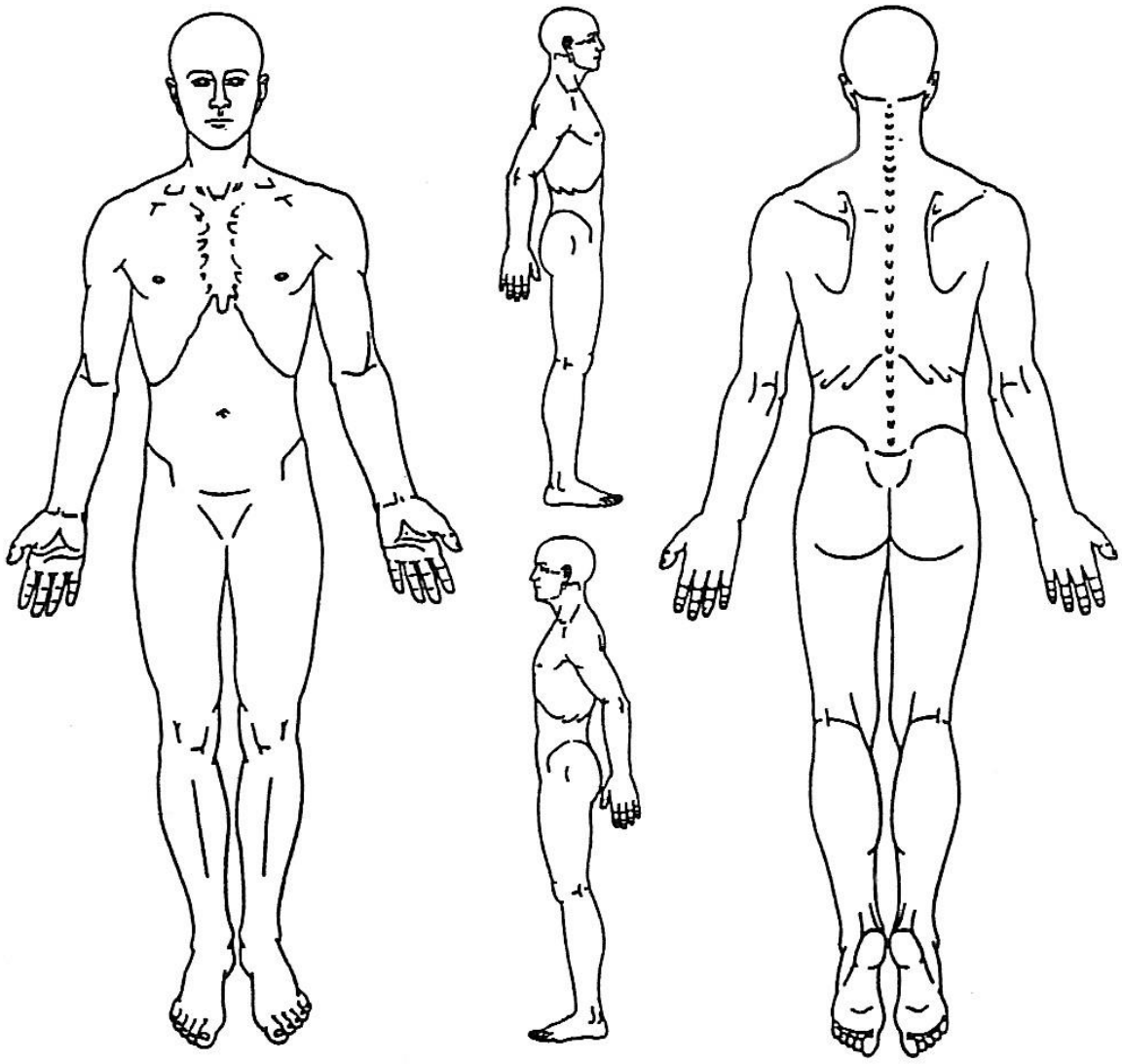
☐ Alcohol/Drug Dependence
☐ Abnormal Menstruation
☐ Allergies
☐ Angina
☐ Arthritis / Rheumatoid Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disorder
☐ Breast Lumps
☐ Cancer / Tumor
☐ Convulsions/Seizures
☐ Diabetes
☐ Diarrhea / Constipation
☐ Excessive Thirst
☐ Fainting or Dizziness
☐ Fatigue
☐ Fever
☐ Frequent Urination
☐ Headache
☐ Heart Attack
☐ Heartburn or Indigestion
☐ High Blood Pressure
☐ Hospitalizations / Surgical Procedures _____
_____
☐ Kidney Disease
☐ Liver Problems
☐ Osteoporosis
☐ Pacemaker
☐ Palpitation / Arrhythmia
☐ Peptic Ulcer
☐ Pregnant, # Weeks
☐ Prostate Problems
☐ Weight Gain / Loss
☐ Sinusitis
☐ Stroke
☐ Tobacco Use – Type
Frequency _____ / Day
☐ Thyroid Disease
☐ Other _____
_____
☐ Medications _____
_____

If a family member has had any of the following, please mark the appropriate box and explain the relationship:
☐ Cancer _____
☐ Heart Disease _____
☐ Hypertension _____
☐ Lupus _____
☐ Other _____

Comments _____

Use the letters below to indicate the type and location of your sensations right now:

Key:	A = Ache	B = Burning Sensation	N = Numbness
	P = Pins & Needles	S = Stabbing	O = Others



I certify that the above information 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 practitioner, I understand that I am liable for all charges for services. I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage. I understand that my practitioner of acupuncture services may need to contact my Primary Care Physician or treating physician if my condition needs to be co- managed. Therefore, I give authorization to my practitioner of acupuncture services to contact my medical doctor if necessary.

Patient Signature _____ Date _____

COSTA ACUPUNCTURE

HEALTH PROFILE - Multiple System Questionnaire (MSQ)	
NAME	
DATE	

Rate each of the following symptoms based upon your typical health profile for the last **60 DAYS**:

Point Scale:
0 - *Never* or *almost never* have the symptom
1 - *Occasionally* have it, effect is *not severe*
2 - *Occasionally* have it, effect is *severe*
3 - *Frequently* have it, effect is *not severe*
4 - *Frequently* have it, effect is *severe*

EXAMPLE:	
Headaches	*2*
HEAD	
Headaches	
Faintness	
Dizziness	
Insomnia	
Total for section	
EYES	
Watery or itchy eyes	
Swollen, reddened or sticky eyelids	
Bags or dark circles under eyes	
Blurred or tunnel vision (does not include near or far-sightedness)	
Total for section	
EARS	
Itchy ears	
Earaches, ear infections	
Drainage from ear	
Ringing in ears, popping ears, hearing loss	
Total for section	
NOSE	
Stuffy nose	
Sinus problems	
Hay fever	
Sneezing attacks	
Excessive mucus formation	
Total for section	
MOUTH/THROAT	
Chronic coughing	
Gagging, frequent need to clear throat	
Sore throat, hoarseness, loss of voice	
Swollen or discolored tongue, gums, lips	
Canker sores	
Total for section	

SKIN	
Acne	
Hives, rashes, dry skin	
Hair loss	
Flushing	
Excessive sweating	
Total for section	
HEART	
Irregular or skipped heartbeat	
Rapid or pounding heartbeat	
Chest pain	
Total for section	
LUNGS	
Chest congestion	
Asthma, bronchitis	
Shortness of breath	
Difficulty breathing	
Total for section	
DIGESTIVE TRACT	
Nausea, vomiting	
Diarrhea	
Constipation	
Bloated feeling	
Belching, passing gas	
Heartburn, reflux	
Intestinal/stomach pain	
Total for section	
JOINTS/MUSCLES	
Pain or aches in joints	
Arthritis	
Stiffness or limitation of movement	
Pain or aches in muscles	
Feeling of weakness or tiredness	
Total for section	

WEIGHT	
Binge eating/drinking	
Craving certain foods	
Excessive weight	
Compulsive eating	
Water retention	
Underweight	
Total for section	
ENERGY/ACTIVITY	
Fatigue, tired, sluggish	
Apathy, lethargy	
Hyperactivity	
Restlessness	
Total for section	
MIND	
Poor memory	
Confusion, poor comprehension	
Poor concentration	
Poor physical coordination	
Difficulty in making decisions	
Stuttering or stammering	
Slurred speech	
Learning disabilities	
Total for section	
EMOTIONS	
Mood swings	
Anxiety/fear/nervous-ness	
Anger/irritability	
Panic attacks	
Depression	
Total for section	
OTHER	
Frequent Illness	
Frequent or urgent urination	
Genital itch or discharge	
Total for section	
GRAND TOTAL	

Additional Information:

COSTA ACUPUNCTURE
ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or the patient named below, for whom I am legally responsible) by licensed acupuncturists who now or in the future treat me while employed by, working or associated with Costa Acupuncture Prof. Corp., including those working at the clinic listed below or any other office or clinic associated with Costa Acupuncture, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

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 Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

(Date)

PATIENT SIGNATURE **X**

(Indicate relationship if signing for patient)

Costa Acupuncture
10200 Venice Blvd. Suite 109B
Culver City, CA 90232

11819 Wilshire Blvd. Suite 212
Los Angeles, CA 90025

Financial Agreement

Costa Acupuncture makes every attempt to make alternative health care available to as many people as possible by offering acupuncture treatments at affordable rates.

If you have acupuncture benefits on your health insurance plan, Costa Acupuncture will bill your insurance provider on your behalf. Verification of insurance benefits does not guarantee payment by your insurance company. If you do not have health insurance or your plan does not cover your treatment at Costa Acupuncture you will be charged our discounted out of pocket rates displayed at our clinic and on our website.

In respect for our intention to offer high quality care at affordable prices, we ask for 24 hours' notice in advance of an appointment if it is necessary to cancel or reschedule your appointment.

All appointments that are missed or canceled with less than 24 hour advance notice will be charged a $20 fee.

Signed: _____ Date: _____

Acknowledgment of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices for the offices of Costa Acupuncture Prof. Corp., detailing how my information may be used and disclosed as permitted under federal and state law.

Signed: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient (e.g., mother) and patient's name.

Patient:_____

Relationship:_____