Byron Barth L.Ac., MSTOM

Office (951) 674-6000
Fax (951) 674-1782
CA License #9779

Name _____ Date _____

Address _____ City _____ State _____

Zip _____ Home Phone (_____) _____ Work Phone (_____) _____

Occupation _____ Person responsible for your account _____

Emergency Contact _____ Phone (_____)_____

How did you hear about us? ☐ Yellow Pages ☐ Internet ☐ Canyon Lake Directory ☐ Community Little Book

☐ Acufinder ☐ Insurance Directory ☐ Colony/Oasis ☐ Referral: _____ ☐ Other: _____

Sex: ☐M ☐ F Height: ____'_____" Birth Date: ____/____/_____ Age: _____

Marital Status: ☐ Married ☐ Single ☐ Domestic Partner ☐ Divorced ☐ Widowed Number of Children: _____

Previous Acupuncture? ☐ Yes ☐ No If so, when? _____

Acupuncturist's Name? _____ Location: _____

Please indicate any significant illnesses you or a blood relative (grandparent, parent, or sibling) have had:

Illness	You	Relative	When?	Illness	You	Relative	When?
Cancer	☐	☐	_____	Diabetes	☐	☐	_____
Hepatitis	☐	☐	_____	Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____	Seizures	☐	☐	_____
Rheumatic Fever	☐	☐	_____	Emotional Disorders	☐	☐	_____
Infectious Diseases	☐	☐	_____	Tuberculosis	☐	☐	_____

Sexually Transmitted Diseases: ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ HPV ☐ Chlamydia ☐ Herpes When? _____

Please indicate the use and frequency of the following:

	Yes	No	Amount		Yes	No	Amount
Coffee / Black Tea	☐	☐	_____	Tobacco	☐	☐	_____
Recreational Drugs	☐	☐	_____	Alcohol	☐	☐	_____
Soda Pop	☐	☐	_____	Water Intake	☐	☐	_____

Please check the box if any of the following statements is true:

I have known allergies	☐	I am taking coumadin / Warfarin	☐
I have a pacemaker	☐	I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs)	☐

List any medications and supplements you are currently taking:

Medicine	Dosage	Reason	How Long	Prescribed By	Date Last Check-up

What are the main health problems for which you are seeking treatment?

What other forms of treatment have you sought?

List any other health problems you now have.

List any allergies, food sensitivities or food craving that you have.

List any accidents, surgeries, or hospitalizations.

Date	Incident

***Lab Results** (Please include copies):*

Date	Lab Test	Result

How do you FEEL about the following areas of your life?

	Great	Good	Fair	Poor	Bad	Your Comments
Significant Other	☐	☐	☐	☐	☐	_____
Family	☐	☐	☐	☐	☐	_____
Diet	☐	☐	☐	☐	☐	_____
Sex	☐	☐	☐	☐	☐	_____
Self	☐	☐	☐	☐	☐	_____
Work	☐	☐	☐	☐	☐	_____
Exercise	☐	☐	☐	☐	☐	_____
Spirituality	☐	☐	☐	☐	☐	_____

FOR WOMEN

Age of 1st period (menarche)_____ Age of last period (menopause) _____

Are you pregnant? ☐ Yes ☐ No # of pregnancies?_____ # of live births? _____

# of abortions? _____ # of Miscarriages? _____ # of days between periods?_____

# of days of flow? _____ Color of flow? _____ Clots? ☐ Yes ☐ No Color _____

Average number of pads you use per day: 1st day _____ 2nd day _____ 3rd day_____ 4th day_____ + days _____

Have you been diagnosed with: ☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ PID ☐ Other _____

Please provide the most recent date for the following procedures:

Date	Procedure	Result
	Pap Smear	
	Mammogram	
	Gynecologic Exam	
	Bone Density Scan	

Location of pain: ☐ Lower abdomen ☐ Lower Back ☐ Thighs ☐ Other _____

Nature of Pain (please indicate before, during, or after menses)			
Cramping		Stabbing	
Burning		Bloating	
Consistent		Intermittent	
Bearing down sensation		Other	

Other Symptoms Related to Menses

☐ Discharge ☐ Vaginal dryness ☐ Headache

☐ Nausea ☐ Constipation ☐ Diarrhea

☐ Swollen Breasts ☐ Mood Swings ☐ Ravenous appetite

☐ Poor Appetite ☐ Hot Flashes ☐ Night Sweats

☐ Increased Libido ☐ Decreased Libido ☐ Insomnia

FOR MEN

Date of last prostate check-up _____ PSA Results _____

Manual prostate exam results _____ Lab Results _____

Frequency of Urination: Daytime _____ Nighttime _____ Color of Urine: ☐ Clear ☐ Murky Odor: _____

Symptoms Related to Prostate

☐ Prostate Problems ☐ Groin Pain ☐ Premature Ejaculation

☐ Rectal Dysfunction ☐ Dribbling ☐ Retention of Urine

☐ Back Pain ☐ Testicular Pain ☐ Impotence

☐ Delayed Stream ☐ Incontinence ☐ Other _____

☐ Increased Libido ☐ Decreased Libido _____

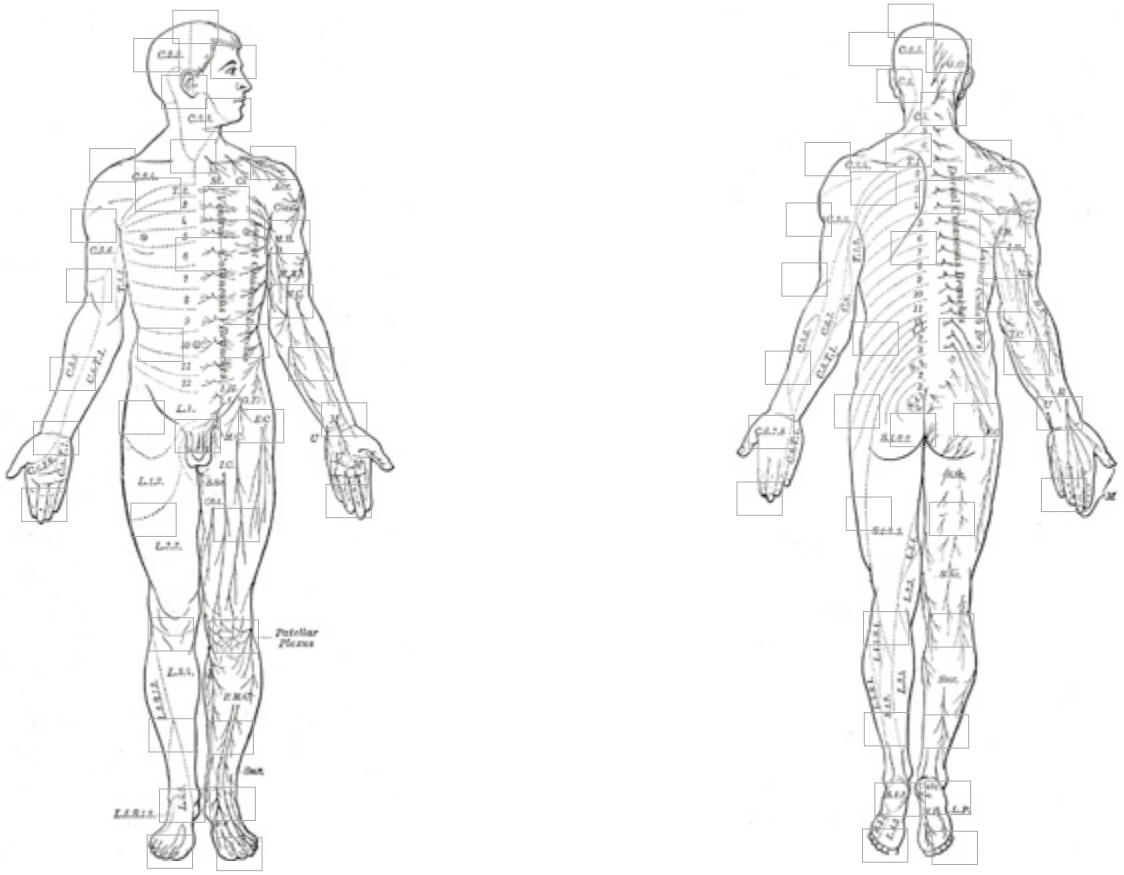
SYMPTOM SURVEY

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:

check mark (✔) frequently experience

____ Lack of appetite	____ Abdominal Pain	____ Jaundice (yellowish eyes or skin)	____ Fatigue
____ Excessive appetite	____ Chest Pain	____ Difficulty digesting oily foods	____ Edema
____ Loose stool or diarrhea	____ Sciatic Pain	____ Gall Stones	____ Blood in stool
____ Digestive problems, indigestion	____ Headaches	____ Light colored stool	____ Black tarry stool
____ Vomiting	____ Pain or coldness in the genital area	____ Soft or brittle nails	____ Easily bruised
____ Belching, burping	____ Cough	____ Easily angered or agitated	____ Difficult to stop bleeding
____ Heartburn / reflux	____ Shortness of breath	____ Difficulty in making plans or decisions	____ Asthma
____ Feeling the retention of food in the stomach	____ Decreased sense of smell	____ Spasms or twitching of muscles	____ Tendency to catch colds easily
____ Tendency to become obsessive in work, relationships	____ Nasal Problems	____ Low back pain	____ Intolerance to weather changes
____ Insomnia, difficulty sleeping	____ Skin Problems	____ Knee problems	____ Allergies
____ Heart palpitations	____ Feeling of claustrophobia	____ Hearing impairment	____ Hay Fever
____ Cold hands and feet	____ colitis or diverticulitis	____ Ear Ringing	____ Dizziness
____ Nightmares	____ Constipation	____ Kidney Stones	____ Tendency to faint easily
____ Mentally restless	____ Hemorrhoids	____ Decreased sex drive	____ Spasms or twitching of muscles
____ Laughing for no apparent reason	____ Recent use of antibiotics	____ Hair Loss	____ High cholesterol levels
____ Angina pains	____ eye problems	____ Urinary problems	____ Sudden weight loss

Please circle or mark the areas of pain, or areas that need special attention on the body map below:



Please remember that insurance is considered a method of reimbursing the patient for fees paid to the Acupuncturist and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records.

I hereby assign all medical benefits, to which I am entitled to, including private insurance and other health plans to:

THIS IS A DIRECT ASSIGNMENT OF RIGHTS AND BENEFITS UNDER THIS POLICY. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient Signature: _____ ***Date:*** _____

Minors Consent

I hereby consent, authorize and request, Byron M. Barth L.Ac., to administer such treatment deemed advisable, necessary or requested on the above minor.

Parent / Guardian Signature: _____ ***Date:*** _____