Van Harding L.Ac.

Neuro-Acupuncture & Medicinals

General Patient Information (Adult)

Name_____ Preferred Name _____
First Middle Last

Driver License/ID _____ Insurance _____
State Number Carrier Policy or ID Number

Address_____ _____ _____ _____
Street City State Zip Code

Home Phone_____ Work Phone _____

Cell Phone_____ Email _____

Occupation:_____ Employer:_____

Best time to reach you: ☐Morning ☐Afternoon ☐Evening Best phone to reach you: ☐Cell ☐Home ☐Work

In case of an EMERGENCY who should we contact? _____ _____
Name Relationship

Cell Phone _____ Home Phone _____ Work Phone _____

Social Security# _____ Language_____ USA Citizen: ☐Yes ☐No

Date of Birth _____ Age _____ Place of Birth _____ Sex ☐Female ☐Male ☐TS
Month Day Year City & State or Country

Genetic background (Please check appropriate boxes) Number of generations in USA: _____

☐African N.American	☐Asian Chinese	☐Caucasian Scandinavian	☐Middle East	☐Russia-Ukraine
☐Native N.American	☐Asian Japanese	☐Caucasian W. European	☐Mediterranean	☐India
☐Central American	☐Asian Korean	☐Caucasian British Isles	☐N. Africa	☐Pacific Islands
☐South American	☐Southeast Asia	☐Caucasian E. European	☐Central Africa	☐Australia – NZ

☐Adopted ☐Unknown Other:_____

Status: ☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Widowed ☐Emancipated Minor

Spouse's name:_____ Age:_____ Occupation:_____

Please check the highest level of education: ☐High School ☐VoTech ☐Bachelor ☐Master ☐Doctorate

Military: ☐Army ☐Navy ☐Marine ☐Air Force Rank:_____ Discharge:_____
Date

Do you have any learning challenges? ☐Yes ☐No If Yes, describe _____

Do you have a disability or a handicap? ☐Yes ☐No If yes, describe_____

2990 South Sepulveda Blvd Suite 310 Los Angeles, Ca 90046 310-310-8096 tel/
fax www.vanharding.com

Notice of Privacy Practices

The privacy of your medical information is important to us and we are committed to protecting it. This notice describes how information about you may be used and disclosed, as well as, how you can get access to this information. Please read this information carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations. These include emergency care, quality assurance activities, payment, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a written request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

In the future we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. We have the right to make changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the information to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

Office for Civil Rights
U.S. Department of Health and Human Services
50 United Nations Plaza - Room 322
San Francisco, CA 94102
415-437-8310 (VOICE); 415-437-8311 (TDD); 415437-8329 (FAX)

Contact Person:
Van Harding
2990 South Sepulveda Blvd
Suite 310
Los Angeles, CA 90046

I,_____hereby acknowledge my receipt of the Notice of Privacy Practices given to me.

Signed: _____ Date: _____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE **X**

(Or Patient Representative) (Date) (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X**

. (Date) (Print Name of signor for Office)

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 on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, 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 need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have 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.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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.

ACUPUNCTURIST NAME: Van Harding LAc	2990 South Sepulveda Blvd Suite 310 Los Angeles, CA 90064	2554 Lincoln Blvd #211 Venice, CA 90291

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship to patient) DATE

Name_____ Date_____

Current or most recent Primary Care Provider:

Name _____ Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain on bottom of page.	☐	☐
3. Are you taking any medication(s) including nonprescription medicine? If yes, please list on bottom of page.	☐	☐
4. Have you ever taken Phen-Fen/Redux?	☐	☐
5. Do you smoke tobacco? Describe usage below.	☐	☐
6. Do you use controlled substances or alcohol? Describe usage below.	☐	☐
7. Women Only: Are you pregnant or think you may be pregnant? Are you nursing? Are you taking oral contraceptives?	☐ ☐ ☐	☐ ☐ ☐

8. Are you allergic to or have you had any reactions to the following:	Yes	No
Local Anesthetics (eg. Novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (eg. Nickel, mercury, etc)	☐	☐
Latex Rubber	☐	☐
Other _____		

9. If you allergic to the following, mark and explain below.

☐ Pollen ☐ Mold ☐ Grass ☐ Foods ☐ Animals

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pain	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Short of Breath	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Mitral Valve Prolapse	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Bleeding tendency	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Work-related Injuries	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other Injuries	☐	☐
Pacemaker	☐	☐	Metal Implants	☐	☐	Other Implants or prosthetics, list:	☐	☐

Family Medical History: Has your father or mother ever had the following?

	Yes	No		Yes	No
Stroke	☐	☐	Mental Disorder	☐	☐
Asthma	☐	☐	High Blood Pressure	☐	☐
Allergies	☐	☐	Diabetes	☐	☐
Cancer	☐	☐	Multiple Sclerosis	☐	☐

Other(s) Parental Health Issues:

_____

_____

_____

List below medications, prior surgeries with dates, and/or current therapy:

_____

_____

_____

_____

_____

_____

_____

_____

Describe usage of tobacco, controlled substances and/or alcohol: Quantity per day, week, etc.

_____

_____

_____

_____

_____

_____

_____

_____

Name_____ Date_____

Review of Systems

Are you allergic to wheat and/or other grains? ☐No ☐Yes, list other grains_____
_____
Do you have other food allergies or sensitivities? ☐No ☐Yes, please list the foods_____
_____
Do you have sensitivity to gluten? ☐No ☐Yes, what do you do to manage it?_____
_____
Do you have dairy sensitivities? ☐No ☐Yes, describe_____
Are you lactose intolerant? ☐No ☐Yes

How often are you affected by airborne allergies? ☐Never ☐Daily ☐Weekly ☐Monthly ☐Seasons
List allergens_____
How often do you experience hives or itching? ☐Never ☐Daily ☐Weekly ☐Monthly ☐Seasons
How often do you have sinus congestion upon waking? ☐Never ☐Daily ☐Weekly ☐Monthly ☐Seasons
How often do you have sinus congestion/stuffiness? ☐Never ☐Daily ☐Weekly ☐Monthly ☐Seasons
How often do you have sinus infections? ☐Never ☐Once per year ☐Several per year

How often do you eat soy? ☐Never ☐Daily ☐Weekly ☐Monthly ☐Less than 4 times per year
Do you crave bread and/or pasta? ☐No ☐Yes
Are there specific foods that make you tired, bloated or foggy thinking? ☐No ☐Yes, please list them_____
_____

Do you often feel spacey or unreal? ☐No ☐Yes, how often?_____
Sensation of something stuck in the throat? ☐No ☐Yes, how often and is there any specific trigger?_____
_____

Do you have alternating constipation and diarrhea? ☐No ☐Yes, how often?_____
Does your pulse increase speed after eating? ☐No ☐Yes, how often and how rapid is the pulse?_____
_____

Do you have bizarre, vivid dreams or nightmares? ☐No ☐Yes, how often?_____

Do you have episodic anger outbursts, intense frustration or easily irritable? ☐No ☐Yes, how often?_____
_____

Which of the following best describes your emotions, thoughts or actions you most frequently experience each day?
Limit your selection to 3 of the following:

☐ Constantly Worry	☐ Overly concerned	☐ Easily startled/frightened
☐ Sadness or Loss	☐ Brood, Bummed-out or disappointment	☐ Procrastinate
☐ Respond with Fear	☐ Hypersensitivity to criticism	☐ Fault-finding, Blaming
☐ Express Anger	☐ Easily Frustrated	☐ Optimistic
☐ Feel slightly 'High'	☐ Seek/Indulge in Pleasure	☐ Pessimistic

Metabolic Assessment Form™

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your 5 major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II

Please check the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3

Category VI *(Cont.)*

Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Category VII

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes		No	

Category VIII

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category IX

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category X

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XI

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIII

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XV *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVIII *(Menstruating Females Only)*

Perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle (greater than 32 days)	Yes	No
Shortened menstrual cycle (less than 24 days)	Yes	No

Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XIX *(Menopausal Females Only)*

How many years have you been menopausal? _____ years

Since menopause, do you ever have uterine bleeding?	Yes	No	
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

~~PART III~~

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

Van Harding L.Ac.

Neuro-Acupuncture & Medicinals

2990 South Sepulveda Blvd Suite 310 Los Angeles, CA 90064 310-310-8096 tel/fax info@vanharding.com

Name _____ Age ___ Sex ___ Date_____

Primary Complaint - Part 1

To Be Determined

Welcome to Acupuncture & Natural Health Primary Care: Please specify a Primary Complaint, which is an acute or chronic health issue, disease or disorder that you would like us to treat. The following is a screening questionnaire to determine suitablility to receive acupuncture today and it is not a complete health history questionnaire.

My Primary Complaint is: _____

Indicate all abnormalities that occur simultaneously with your Primary Complaint:

☐ Balance	☐ Appetite	☐ Hypertension	☐ Energy	☐ Addiction	☐ Injury (Past)
☐ Hearing	☐ Defecation	☐ Heart Rate	☐ Libido	☐ Attitude change	☐ Injury (Recent)
☐ Smell	☐ Digestion	☐ Respiration	☐ Menses	☐ Behavior change	☐ Fertility
☐ Speech	☐ Thirst	☐ Skin	☐ Semen flow	☐ Cravings	☐ Weight
☐ Swallowing	☐ Urination	☐ Sweating	☐ Sleep	☐ Emotions	☐ Pain (physical)
☐ Taste	☐ Bleeding	☐ Cough	☐ Excess naps	☐ Mental function	☐ Twitching-Ticks
☐ Touch	☐ Mucus flow	☐ Gaging		☐ Memory	☐ Hiccups
☐ Vision	☐ Swelling			☐ Pain & Emotions	

Check those that apply:

☐Yes ☐No First time experiencnig acupuncture
☐Yes ☐No Fear of needles
☐Yes ☐No At this moment you are hungry
☐Yes ☐No Hypotension (low blood pressure)
☐Yes ☐No Orthostatic hypotension - experience dizziness or light-headedness after standing up
☐Yes ☐No Feel chills or feverish at this moment
☐Yes ☐No History of seizures of unknown cause
☐Yes ☐No Episodes of uncontrolled bleeding
☐Yes ☐No Persistant or constant headache
☐Yes ☐No Recent traumatic head or body injury not seen by MD
☐Yes ☐No Under the influence of alcohol, recreational drugs, Over the Counter drugs, prescription medications

☐ HIV ☐ AIDs ☐ Hepatitis ☐ Active Tuberculosis
☐ Neuropathy ☐ Numbness ☐ Burning sensation

What problems are posed by the PC and what are your concerns if it is not resolved?

_____
_____
_____
_____
_____
_____

Which emotion do you experience most of the time?
☐ Worry-concern ☐ Frustration ☐ Anger ☐ Fear
☐ Grief-Sad-Loss ☐ Revved-up ☐ Uncertain ☐ None

When you sleep, check those that apply:

☐ Difficulty falling asleep
☐ Difficulty remaining asleep
☐ Awakened & cannot reseume sleep
☐ Awakened to urinate
☐ Awakened by hunger
☐ Vivid dreams
☐ Nightmares
☐ Nightsweats
☐ Racing mind
☐ Require sleep aids
  ☐ White noise
  ☐ Medication
  ☐ Alcohol
  ☐ Music
  ☐ TV in background

Consumed the following within 1 hour of this session?
☐ Caffeine ☐ Nicotine ☐ Ginseng
☐ Sudafed ☐ Chocolate ☐ Alcohol

Name:_____ Date_____

Physical Sensation - Part 2a

Primary Complaint: Pain - Numbness - Tingling

Instructions: Use this form to indicate any Physical Sensations you are or have been experiencing. This maybe your Primary Complaint, it maybe assocaited with your Primary Complaint or it may not be of significant concern as of today,

Name your Primary Complaint: ☐ Pain Complex Regional ☐ Numb or Tingling ☐ Headaches & Migraine
☐ Phantom & Residual Limb ☐ Arthritis & Joint ☐ Back & Neck ☐ Other_____

Indicate all abnormalities or exacerbated conditions that occur simultaneously with Physical Sensation:

☐ Balance	☐ Appetite	☐ Blood pressure	☐ Energy	☐ Addiction	☐ Fertility
☐ Hearing	☐ Defecation	☐ Arrythmias	☐ Libido	☐ Attitude change	☐ Pain (physical)
☐ Smell	☐ Digestion	☐ Angina	☐ Menses	☐ Behavior change	☐ Twitching-Tics
☐ Speech	☐ Thirst	☐ Breathing	☐ Vaginal fluids	☐ Cravings	☐ Hiccups
☐ Swallowing	☐ Urination	☐ Skin	☐ Semen flow	☐ Emotions	☐ Self Esteem
☐ Taste	☐ Bleeding	☐ Hair	☐ Sleep	☐ Mental function	☐ Self Image
☐ Touch	☐ Mucus flow	☐ Nails	☐ Excess naps	☐ Memory	☐ Motivation
☐ Vision	☐ Swelling			☐ Pain (from emotions)	

Is this your first time seeking treatment for the primary complaint? ☐ Yes ☐ No, I have sought _____ prior.
No. of times

When did the primary complaint become disruptive to your ADL, caused significant impairment or prompted treatment?
_____
How many days, weeks, months or years ago or the date.

When did the primary complaint or associated symptoms begin before the condition became disruptive to your Activities of Daily Living or caused significant impairment?
_____
Indicate the number of days, weeks, months or years or the date.

How frequently does the primary complaint or associated symptoms interfere with Activities of Daily Living?
_____
Indicate number of minutes, hours in a day or number of days/weeks

What do you think is the origin or cause of the primary complaint? _____
_____

What provides relief to the primary complaint? _____
_____
_____
_____

Please answer the following:

Are you willing to have blood tests?	☐ No	☐ Yes	☐ Unknown
Does excess weight caused pain?	☐ No	☐ Yes	☐ Unknown
Has excess weight damaged joints?	☐ No	☐ Yes	☐ Unknown
Does a sibling have this weight issue?	☐ No	☐ Yes	☐ Unknown
Does a parent have this weight issue?	☐ No	☐ Yes	☐ Unknown
Are you lactose intolerant?	☐ No	☐ Yes	☐ Unknown
Are you gluteomorphin reactive?	☐ No	☐ Yes	☐ Unknown
Are you caseomorphin reactive?	☐ No	☐ Yes	☐ Unknown
Do you have a food allergy?	☐ No	☐ Yes	☐ Unknown
Are you on prescription medication?	☐ No	☐ Yes	
Are you taking OTC medicines?	☐ No	☐ Yes	
Are you taking illicit drugs?	☐ No	☐ Yes	
Are you taking herbs?	☐ No	☐ Yes	
Do you smoke tobacco?	☐ No	☐ Yse	

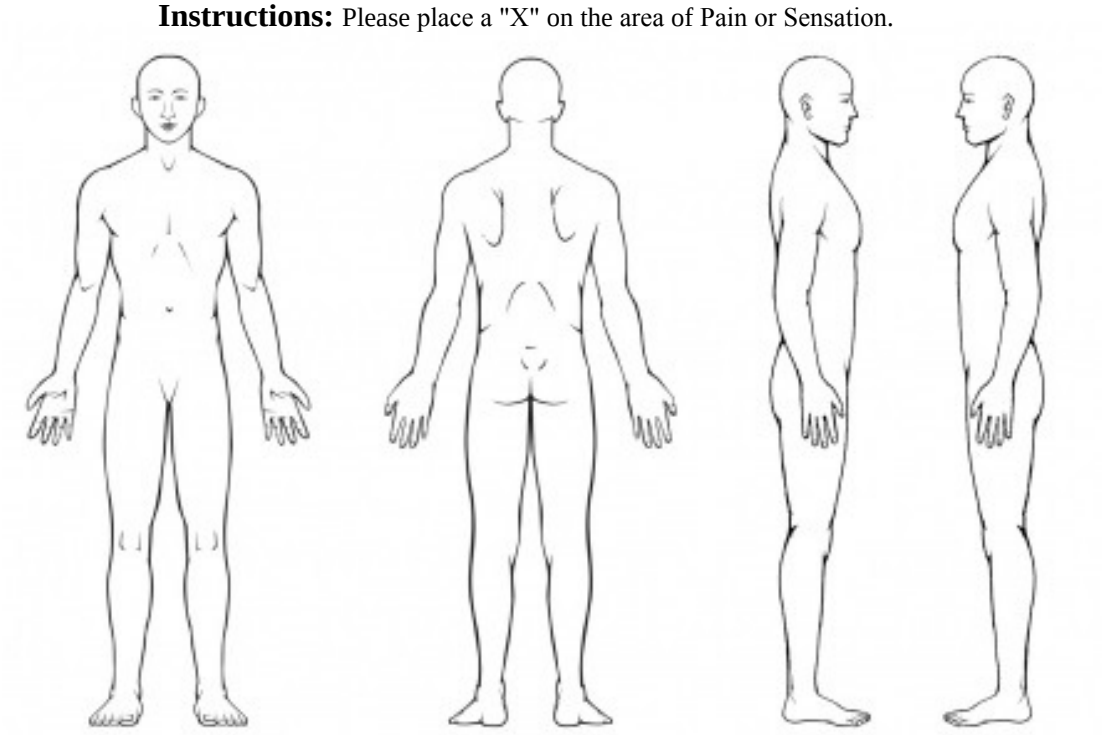
If you need to include more information, write it in a MSWord documents and title it with your name and Primary Complaint.
Example: John_Doe_Physical Sensation Part 1a

Name:_____ Date_____

Physical Sensation - Part 2b

Primary Complaint: Pain - Numbness - Tingling

Instructions: Please place a "X" on the area of Pain or Sensation.



Front Rear Right Left

Type of Pain or Sensation:

- ☐ Sharp
- ☐ Shooting
- ☐ Throbbing
- ☐ Burning
- ☐ Dull
- ☐ Aching
- ☐ Tingling
- ☐ Numbness
- ☐ Cramping
- ☐ Tightening
- ☐ Stiffness
- ☐ Swelling
- ☐ Heat
- ☐ Cold
- ☐ Crawling
- ☐ Itching

Quality.of Primary Complaint:

- ☐ Constant ☐ Fixed
- ☐ Intermittent ☐ Moving

Trigger or Aggrivated by:

- ☐ Cold ☐ Heat
- ☐ Physical activity
- ☐ Emotional upset
- ☐ Stress ☐ Weather

Rate your pain at it's most and least painfulness:

- ☐ 0 None
- ☐ 1 Mild - nagging, annoying, interferes little with ADLs
- ☐ 2 Mild - nagging, annoying, interferes little with ADLs
- ☐ 3 Mild - nagging, annoying, interferes little with ADLs
- ☐ 4 Moderate - Interfere's significantly with ADLs
- ☐ 5 Moderate - Interfere's significantly with ADLs & need OTC med
- ☐ 6 Moderate - Interfere's significantly with ADLs & need OTC med
- ☐ 7 Severe - Disabling, unable to perform ADLs & Need Rx med
- ☐ 8 Severe - Disabling, unable to perform ADLs & Need Rx med
- ☐ 9 Severe - Disabling, unable to perform ADLs & Need Rx med
- ☐ 10 Severe - Disabling, unable to perform ADLs & Need hospital

Are you hands or feet too sensitive to touch? ☐ Yes ☐ No
Does it hurt at night when bed covers touch? ☐ Yes ☐ No
Do your symptoms worsen at night? ☐ Yes ☐ No
Do your legs feel weak when you walk? ☐ Yes ☐ No
Do your legs/feet hurt when you walk? ☐ Yes ☐ No
Are your feet skin dry and crack open? ☐ Yes ☐ No
Can your feet discern hot/cold water in tub/shower? ☐ Yes ☐ No
Do your legs/feet experience 'asleep feeling' or loss of sensation? ☐ Yes ☐ No
Are you unable to sense you feet when you walk? ☐ Yes ☐ No
Do you have sharp, stabbing or shooting pain in our feet? ☐ Yes ☐ No

What provides relief of Pain or sensation?_____

_____

_____

_____

_____

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Physical Sensation Part 1b