Acupuncture – Cathy Margolin

Los Angeles Center for Healing
1157 S. Robertson Blvd.
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Cathy Margolin, L.Ac., Dipl. O.M.

Welcome to Acupuncture and the Los Angeles Center for Healing. Acupuncture is a safe and effective way to achieve and maintain health. Your first visit as an acupuncture patient will include a complete medical history, an acupuncture treatment, and an herbal consult (optional depending on reason for the visit and patient preference). Please feel free to ask any questions regarding your treatment. Many of the procedures may be a new experience for you and it is important for you to be able to relax during the treatment and afterward as well. Thank you for choosing Acupuncture us for your health care needs.

1. **Payment for Services Rendered**: You are responsible for all services received at this office and are expected to pay in full at the time of service. We will provide a receipt and super bill for you to submit to your insurance company. Different insurance companies and plans reimburse services differently. Any supplements or herbs that you receive are to be paid for at the time you receive them. If you are experiencing financial difficulty, please talk with one of us at the front desk.

2. **Cancellations:** Cancellations made with less than 24 hours notice will be charged the full fee. In case of emergency it is up to the clinician as to whether or not you will be charged.

3. **Supplements/herbs:** Please give us 2-3 days notice if you need refills.
I agree to all of the above conditions:

Signature _____ Date_____

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PATIENT INTAKE FORM Date: _____

Name_____Phone Home ( )_____Work( )_____E-Mail_____
Street_____City:_____State:_____Zip_____
Date of Birth_____Age:_____Height:_____Occupation:_____
Marital Status:_____Number of children:_____Referred By:_____
Social Security #_____Physician:_____Date of last exam:_____
Emergency Contact: _____Relationship:_____Phone( )_____

Health History Questionnaire
Successful health care and preventive medicine are only possible when the healthcare practitioner has a complete understanding of the patient physically, mentally and emotionally. To assist me in best serving you, please complete this questionnaire as thoroughly as possible. Print all information and mark anything you do not understand with a question. Thank you.
What is your primary concern, condition, injury or illness?_____
_____
Date it began:_____
Describe what caused it or how it started: _____
_____
_____
How does this condition affect you?_____
Have you had this condition or similar condition before?_____
Have you received treatment for this condition?_____If yes,When?_____
From Whom?_____what was the diangnosis?_____
Results?_____
Is the condition: _____Better ____Worse _____about the same
Patient Name_____ Date_____
What makes the condition better?_____
What makes the condition worse?_____
What do you think is happening? And why?_____
_____
What are your most important health concerns? List as many as you can in order of importance.
1] _____
2] _____
3] _____
4] _____

Patient Name_____ Date_____

Family Medical History: [this refers to your extended family]
_____ Cancer _____Diabetes _____Allergies
_____ High-Low Blood Pressure _____TB _____Asthma
_____ Heart Disease _____Epilepsy _____Hives
_____ Kidney Disease _____Ulcers _____Sinus Problems
_____ Liver Disease _____Arthritis _____Alcoholism
_____ Eye Disease _____Stroke _____Hayfever
_____ Mental Disorders _____Anemia _____Drug Addiction
_____ Spinal Problems _____Other_____
Age Parents Died and Cause of Death: Mother_____
Father_____

Personal Medical History: [Include Date]:
Major Surgeries: _____
Illnesses: _____
Diseases: _____
Accidents: _____

Childhood Illnesses: [Circle Yes or No]

Y N Scarlet Fever Y N Diphtheria Y N Mumps
Y N Rheumatic Fever YN German Measles Y N Measles

Allergies:
Are you hypersensitive or allergic to: Any
drugs?_____
Any Foods?_____

Current Medications: Do you take or use:
Laxatives Y N Pain Relievers Y N Antacids Y N
Cortisone Y N Appetite Suppressants Y N Antibiotics Y N
Tranquilizers Y N Thyroid Medication Y N Sleeping Pills Y N
Please list any prescription medications, over the counter medications, vitamin, and other supplements you are taking.
1]_____ 4]_____
2]_____ 5]_____
3]_____ 6]_____
Contagious Diseases: Check if you have ever had any of the following:
_____Hepatitis _____Herpes _____Veneral disease
_____HIV+ _____AIDS _____Other_____
Lifestyle:

Patient Name_____ Date_____

Habits: please mark box with 'P' for past use and with "C" for current use.
_____Cigarettes _____Soft Drinks _____Salt
_____Coffee _____Alcohol _____Recreational Drugs
_____Black Tea _____Sugar _____Stress
Have you ever been treated for alcoholism or drug dependence? Y N

Exercise:
____None _____Little _____Moderate ____Heavy
What exercise do you regularly do and how often?_____
Do you do any form of realization regularly? _____Yoga _____Tai Chi
____Meditation ____Qi Gong _____Guided Relaxation _____Breathwork

Emotions: Check all that apply. Put 2 check by the two most predominant ones in your life
___Happy ___Easily Irritable ___Restless ___Angry
___Cry Easily ___Hurry to do things ___Depression ___Stressed
___Anxious ___Other_____

Do you have a history of physical or emotional abuse? Y N
Have you experienced any major traumas? Y N More than 2 in 1 yr.? Y N
[i.e. divorce, change of residence, injury, loss of job, death in family, bankruptcy, etc.]
Do you enjoy your work? Y N
Do you have a supportive relationship? Y N

Diet: Check which you eat typically.
____Beef ____Eggs ___Cheese ___Grains ___Tofu ___Pork
____Bread ___Margarine ___Fried Foods ___Yogurt ___Poultry ___Milk
____Butter ___Sweets ___Fish ___Salads ___Vegetables
____Ice cream ____Health foods ___Hot Spicy Food
Other:_____ Cravings:_____
Do you eat 3 meals per day? Y N Do you eat at regular times? Y N
Appetite:
_____Up & Down ____Poor ____Good _____Hungry A Lot ____Loss of Taste
Weight:
_____ Normal ____Underweight ___Overweight ____Recent Gain ____Recent Loss
energy:
____Up & Down ___Low _____Normal ____Excess ____Low after Eating
____Tired in Afternoon
General Symptoms: Put check mark if experiencing any of these symptoms now
____Warm Natured ___Flush Face ___Feel Warmer Late Afternoon & Night
____Cold Natures ___Warm Palms ___Alternate Chills & Fever
____Cold Hands & Feet ___Warm Soles ___Normal
____Aversion to Cold ___Aversion to Heat ___Aversion to Wind
Other: _____
perspiration:
___Very Little ___Easily ___Nightsweats ___Profuse
___Palms ___Bad Smell ___Without exertion ___Feet
___Normal Other:_____

Patient Name_____ Date_____

Digestion:
___Indigestion __Nervous Stomach ___Bloating
___Heartburn __Nausea/Vomit ___Belch/Burp
___Gall Stones __Stomach Noises ___Bad Breath
___Gas __Abdominal Pain/Cramps ___Weight Problem
___Bitter Taste __Full Feeling/Distention ___Normal
___Difficulty Digesting Fatty/Oily Foods Other: _____

Bowels:
_____Loose Stool ____Blood in Stool _____Diarrhea
_____Undigested food in Stool ____Stool with Bad Smell _____Hemorrhoids
_____Constipation ____Anus Itch _____Mucous in Stool
_____Colon Problems ____Burning Anus _____Black Stool
_____Small Amount of Stool ____Hard Stool _____Intestinal Worms
_____Pain or Cramps ____Laxatives Used _____Normal
Other: _____
Urination: [3-4 times per day is normal]
_____Frequent ____Burning _____Bladder Infections
_____Urgency ____Nighttime _____Blood
_____Incontinence ____Profuse _____Pus
_____Kidney Stones/Infections ____Strong Smell _____Painful
_____Cloudy ____Scanty _____Not Normal Color
_____Normal Other_____
Thirst:
_____Less than Normal ____Excessive_____Prefer Cold Drinks
_____Thirsty but do not Drink ____Prefer Hot Drinks _____Normal
Sleep:
_____Difficulty Falling Asleep _____Lots of Dreams _____Awaken Easily
_____Sleep too Much _____Tired on Rising in A.M. _____Nightmares
_____Restless _____Difficulty going back to Sleep _____Insomnia
_____Vivid Dreams _____Normal _____Hours of sleep
Headaches/Dizziness:
____Headaches _____Vertigo _____Dizzy on Standing _____Dizziness
____Motion Sickness _____Poor Balance _____Faint Easily _____Migraines
____Poor Memory _____Normal Other:_____
Skin:
____Dry _____Hives _____Clammy Skin _____Shingles
____Oily _____Pimples _____Bruise Easily _____Dry Scalp
____Rashes _____Moles _____Cuts Heal Slowly _____Cysts
____Itching _____Warts _____Yellow Skin _____Tumors
____Eczemza _____Boils _____Ulcers _____Body Odor
____Herpes Simplex _____Normal Other: _____
Hair:
____Dry ____Oily ____Dandruff ____Early Grey ___Thinning or loss ____Normal

Patient Name_____ Date_____

Nails:
____Soft ___Spots ___Grow Slow ___Grow Fast
____Pale ___Break Easily ___Ridges & Lines ___Purple
____Normal Other: _____

Eyes:
___Wear Glasses of contacts ___Eyelids Swollen ___Cataracts
___Spots or Lines in vision ___Inflammation ___Glaucoma
___Pale Under Eyelids ___Yellow Sclera ___Blink
___Poor Night Vision ___Failing Vision ___Itch
___Sensitive to Light ___Sty History ___Twitch
___Color Blindness ___Blurry Vision ___Pain
___Dark Under the Eyes ___Tear Easily Other:_____

Nose:
___Stuffy Nose ___Hayfever ___Sneeze a lot ___Rhinitis
___Mucous ___Bleeding ___Loss of smell ___Sinusitis
___Blow Nose a Lot ___Normal ___Environmental Sensitivity
Other:_____

Mouth & throat:
___Dry ___Gum Problems ___Hoarseness
___Frequent Sore Throats ___Sores in Mouth/Tongue ___Frequent Colds
___Difficulty Swallowing ___Dry Cracked Lips ___TMJ Syndrome
___Thyroid Problem ___Hiccups ___Drool A Lot
___Swollen Glands ___Grind Teeth ___Teeth Problems
___Bitter Taste in Mouth ___Feel Lump in Throat ___Loose Teeth
___Tonsilitis ___Normal Other: _____

Ears:
___Hearing Loss ___Sensitive to Cold ___Sensitive to Noise
___Ringing in Ears-High Pitch ___Ringing -Low Pitch ___Normal
Other:_____

Respiratory:
___Shortness of Breath ___Difficulty Inhaling ___Sigh a Lot
___Chest Pain ___Difficulty Exhaling ___Dry Cough
___Asthma ___Shallow Breathing ___Cough with Phlegm
___Bronchitis ___Cough A Lot ___Cough with Blood
___Tightness in Chest ___Difficulty Breathing when Lying Down
___Normal Other:_____

Patient Name_____ Date_____

Cardiovascular-circulation:
___Diagnosed Heart Problems ___Palpitations ___Bleed Easily
___Broken Vessels/Capillaries ___Low Blood Pressure ___High Blood pressure
___Purple Vessels/Capillaries ___Murmur ___Varicose Veins
___Ankle Swelling ___History of Anemia ___Chest pain
___Facial Swelling ___Slow Heartbeat ___Bruise Easily
___Hand Swelling ___Fast Heartbeat ___Irregular Heartbeat
___Numbness of Extremities ___ Normal Other: _____

Pain:
___Low Back ___Neck ___Shoulder
___Sciatica ___Spine ___Hands or wrists
___Mid Back ___Knees ___Hips
___Upper Back ___Foot or Ankle ___Arthritis
___Fullness below ribs ___Weak Legs/Knees ___Nerve Pain
___Muscle Weakness ___Muscle Cramps ___Flank Area
___Muscle twitching or spasm ___Damp Weather Bothers You
Other:_____

Miscellaneous:
Are there any other problems you would like to discuss?_____

Males Only: Please check or explain as applicable.
___Reduced Sex Drive_____
___Premature Ejaculation_____
___Seminal Emission_____
___Impotence_____
___Discharge_____
___Genital Pain_____
___Prostate Problems_____
___Painful or Burning Urine_____
___Dribbling of Urine_____

For Females Only:
Are you or might you be pregnant?___Y ____N ___Maybe
If Yes, Approximate date of conception?_____
Are you experiencing reduced sex drive? ___Y ___N
Are you experiencing other difficulties? ___Y ___N
Explain:_____
Regular PAP tests? __Y ___N How Regular?_____Date of last PAP_____

Patient Name_____ Date_____

Do You have facial hair or excess body hair? ___Y ____N
Do you have or do yourself regular breast exams? ___Y ____N
How Regular?_____-

Menstual cycle: Please check and explain as applicable.
Age started_____ Days of Flow_____ Age Stopped_____
How many days from the beginning of your period to the start of your next period?_____
___Irregular_____
___Painful_____
___Heavy Flow_____
___Scanty Flow_____
___Dark Color Flow_____
___Light Color Flow_____
___Clotting_____
___ PMS_____
___Water Retention_____
___Abdominal Bloating_____
___Painful or Tender Breasts_____
___Emotional Changes_____
___Spotting Between Periods_____
___Lump in Throat Feeling_____
___Constipation and/or Diarrhea_____
___Tightness on Chest_____
___Hormonal Problems_____
___Backache_____
___Sigh A Lot_____

Vaginal Discharges:
___Yellow _____
___Thick_____
___Bad Odor_____
___White_____
___Clear_____
___Other_____
Ovulation Symptoms_____
Menopause Problems_____

Pregnancies:
Total Number _____Number of Miscarriages_____Number of Children_____
Number of Abortions_____

Patient Name_____ Date_____

Pregnancy or Childbirth Complications
_____
_____
_____
_____

Gynecological History or Operations:

___Ovaries_____
___Uterus_____
___Fallopian Tubes_____
___Vagina_____
___Breasts_____
___Other_____

What method of birth control do you use now?_____
What methods of birth control have you used in the past?_____
_____

Thank you for completing this questionnaire. Your answers will assist in planning the most appropriate treatment for your condition{s} based on your lifestyle and constitutional profile. If you have any questions, please ask.
Date:

Tongue: Pulse: Rate:

Left: Right:

Diagnosis:

Treatment Plan:

Recommendations:

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