Dzogchen Healing Center

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Welcome to the Dzogchen Healing Center. To help us provide you with the best possible care, please fill out this form as accurately as possible. All the information will be kept confidential in your patient file.

Name: Birth Date: / /

Mailing Address:

City: State: Zip: Sex: F M

Home Phone: ( ) Marital Status: Single Married Other

Work/Cell Phone: ( ) Occupation:

In case of emergency, contact:

Relationship: Telephone: ( )

How did you hear about us?

Do you have: Medi-Cal? Yes No

Out of county? Yes No

Do you have Private Insurance? Yes No

If ***yes***, please fill out our ***Insurance Verification Form***

Are you being treated elsewhere? Yes No

For what complaint?

Personal Physician's Name:

Are you currently using prescription or herbal medicines? Yes No If yes, please list below:

MEDICAL HISTORY: Check all of the boxes below that are now or have been a part of your personal health history.

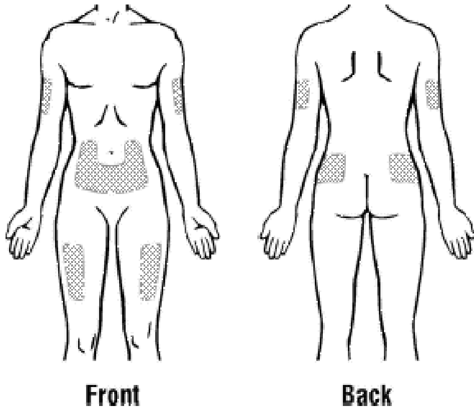
	Current	Past		Current	Past		Current	Past
Arthritis	❑	❑	Chronic Fatigue	❑	❑	HIV +	❑	❑
Abortion	❑	❑	Diabetes	❑	❑	Hypoglycemia	❑	❑
			(specify) ________					
Allergies	❑	❑				Injuries	❑	❑
(specify) ________			Digestive Disorders	❑	❑	Insomnia	❑	❑
Anemia	❑	❑	Emphysema	❑	❑	Irregular Pregnancy	❑	❑
Asthma	❑	❑	Epilepsy	❑	❑	Menstrual Irregularity	❑	❑
Bleeding Tendency	❑	❑	Headaches	❑	❑	Psychological Disorders	❑	❑
Blood Pressure-High	❑	❑	Heart Disease	❑	❑	Surgery	❑	❑
Blood Pressure-Low	❑	❑	Hepatitis	❑	❑	Vaginal Infections	❑	❑
Bronchitis	❑	❑	***(Specify Type)*** A___ B___ C___			Thyroid	❑	❑
Cancer	❑	❑	Heavy Bleeding	❑	❑	Other: ________		
(specify) ________								

LIFESTYLE: Which of the following is/are part of your lifestyle?

❑ Tobacco Smoking ❑ Recreational Drugs ❑ Exercise
❑ Coffee Drinking ❑ Birth Control Pills ❑ Relaxation/Meditation
❑ Alcohol Drinking ❑ Special Diet(specify____________) ❑ Vitamins/Supplements

PLEASE TURN OVER.....COMPLETE & SIGN THE OTHER SIDE

PLEASE INDICATE WITH AN "X" ANY AREAS OF PAIN OR INJURY:



- ❑ Sudden Onset vs ❑ Gradual Onset
- ❑ Constant vs ❑ Intermittent
- ❑ Sharp vs ❑ Dull

- ❑ Spasms/Tremor ❑ Stiffness
- ❑ Numbness ❑ Tingling
- ❑ Swelling/Edema ❑ Burning
- ❑ Bruising/Tenderness ❑ Radiating to_____________

CHIEF COMPLAINT(S):

OFFICE POLICY:

All fees for medical services are due at the time of visit unless arrangements have been made between Dzogchen Healing Center and your insurance company. Dzogchen Healing Center will bill for insurances that cover Acupuncture/TCM. Please note that all published prices reflect a courtesy discount for cash patients.

If you need to cancel an appointment, please give us a minimum of 24 hours notice.
There may be a $25 cancellation fee for less than 24 hour notification.

Please Initial Here: ____________

◆ My signature authorizes Dzogchen Healing Center to treat me (or the patient for whom I am legally responsible) with acupuncture and Chinese medicinal herbs within the licensure granted by the Medical Quality Assurance Board of the State of California and the California Acupuncture Committee.

◆ I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgement during the course of the procedure, which the acupuncturist feels based upon the facts then known, is in my best interests.

◆ 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.

◆ I authorize the release of any medical or other information necessary for insurance claim processing and I understand that my individually identifiable medical information will be used only as necessary for purposes of treatment, payment, and other healthcare operations.

◆ I have received the Dzogchen Healing Center Notice of Privacy Policies.

Signature: ____ Date: ________________
(Patient, Parent or Guardian)

FOR OFFICE USE ONLY:

Witness to Patient's Signature: ______________________________ Date:________________
(Staff or Acupuncturist)