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

Marital Status: Single Married Other

Home Phone: ( ) Work/Cell Phone: ( )

E-mail:

Occupation: Employer's Name:

Employer's Address: Employer's Tel: ( )

In case of emergency,

Contact Person: Relationship: Telephone: ( )

How did you hear about us?

Insurance Information

Primary Insurance:
Insurance Billing Address: Contact Tel: ( )
Policy Holder Name: Policy Holder Birthday: Relationship:
Policy ID: Group#:

Secondary Insurance (if any):
Insurance Billing Address: Contact Tel: ( )
Policy Holder Name: Policy Holder Birthday: Relationship:
Policy ID: Group#:

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:

Assignment and Release:

I hereby assign my insurance benefits to be paid directly to the provider of service. I understand that I am financially responsible for any non-covered services. I also authorize the provider to release any information required to process any claim.

Signed: ____ Date: _____________________

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

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

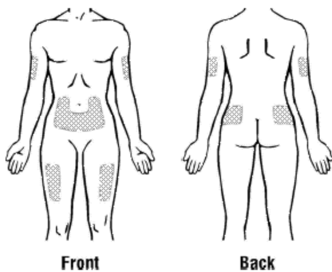
Family Health History

	self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood Disorder							
Diabetes							
Cancers/ Tumors							
Seizures							
High Blood Pressure							
Kidney/ Bladder disorder							
Drug Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression/anxiety							
Digestive system disorder							
Other							
Age at death							

Major Hospitalizations - If you have ever been hospitalized for any serious medical illness or operation, write in your most recent hospitalizations below.

Year	*Operation or illness*	*Name of Hospital*	*City and state*

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



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

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

CHIEF COMPLAINT(S):

Personal Health Information Check Table

GENERAL
Past / current
( ) ( ) Appetite
( ) ( ) Insomnia
( ) ( ) Fatigue
( ) ( ) Fevers
( ) ( ) Night Sweats
( ) ( ) Sweat easily
( ) ( ) Chills
( ) ( ) Localized Weakness
( ) ( ) Poor coordination
( ) ( ) Change in Appetite
( ) ( ) Strong Thirst

SKIN AND HAIR
Past/ current
( ) ( ) Rashes
( ) ( ) Hives
( ) ( ) Itching
( ) ( ) Eczema
( ) ( ) Pimples
( ) ( ) Dryness
( ) ( ) Tumors, Lumps

HEAD AND NECK
Past / current
( ) ( ) Dizziness
( ) ( ) Fainting
( ) ( ) Neck stiffness
( ) ( ) Enlarged lymph
( ) ( ) Headaches

EARS AND EYES
Past/ current
( ) ( ) High pitch ringing
( ) ( ) Low pitch ringing
( ) ( ) Blurred vision
( ) ( ) Visual change
( ) ( ) Poor night vision
( ) ( ) Cataracts
( ) ( ) Spots
( ) ( ) Eye inflammation

NOSE/ MOUTH
Past/ current
( ) ( ) Running nose
( ) ( ) Sinus infection
( ) ( ) Allergies
( ) ( ) Sore throat
( ) ( ) Grinding teeth
( ) ( ) Mouth sores

CARDIOVASCULAR
Past/current
( ) ( ) high blood pressure
( ) ( ) low blood pressure
( ) ( ) Blood clots
( ) ( ) Palpitations
( ) ( ) Fainting
( ) ( ) Chest pain
( ) ( ) Irregular heart beat
( ) ( ) Cold hands/feet
( ) ( ) Swelling hand/feet

RESPIRATORY
Past/ current
( ) ( ) Asthma
( ) ( ) Bronchitis
( ) ( ) Frequent colds
( ) ( ) Pneumonia
( ) ( ) Cough
( ) ( ) Coughing blood
( ) ( ) Production of phlegm

GASTRO-INTESTINAL
Past/ current
( ) ( ) Nausea
( ) ( ) Vomiting
( ) ( ) Diarrhea
( ) ( ) Belching
( ) ( ) Blood in stools/
( ) ( ) Bad breath
( ) ( ) Rectal pain
( ) ( ) Hemorrhoids
( ) ( ) Constipation
( ) ( ) Pain or cramps
( ) ( ) Indigestion
( ) ( ) Gallbladder disorder
( ) ( ) Gas

GENITO-URINARY
Past/current
( ) ( ) Kidney stones
( ) ( ) Pain on urination
( ) ( ) Frequent urination
( ) ( ) Blood in urine
( ) ( ) Urgency to urine
( ) ( ) Unable to hold urine

MALE
Past/ current
( ) ( )Pain/itching of genitalia
( ) ( ) Genital lesions/ discharge
( ) ( ) Impotence
( ) ( ) Weak urinary stream
( ) ( ) Lumps in testicles
( ) ( ) Frequent urination

FEMALE
Past/current
( ) ( ) Frequent urination
( ) ( ) Vaginal infections
( ) ( ) Pain/itching of genitalia
( ) ( ) Pelvic inflammatory disease
( ) ( ) Abnormal Pap Smear
( ) ( ) Irregular periods
( ) ( ) Painful menstrual periods
( ) ( ) Genital lesions/discharge
( ) ( ) Premenstrual syndrome
( ) ( ) Abnormal bleeding
( ) ( ) Menopausal syndrome
( ) ( ) Breast lumps

NEUROLOGICAL
Past/current
( ) ( ) seizures
( ) ( ) tremors
( ) ( ) Numbness/ tingling of li
( ) ( ) Concussion
( ) ( ) Pain
( ) ( ) Paralysis

PSYCHOLOGICAL
Past./current
( ) ( ) Depression
( ) ( ) Anxiety./ stress
( ) ( ) Irritability
( ) ( ) Bi-polar
( ) ( ) Emotional disease

INFECTION SCREENING
Past/current
( ) ( ) HIV
( ) ( ) TB
( ) ( ) Hepatitis
( ) ( ) Gonorrhea
( ) ( ) Chlamydeous
( ) ( ) syphilis
( ) ( ) Genital warts
( ) ( ) Herpes oral
( ) ( ) genital Herpes

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)