CONNIE LOCK-BOUVIER, LAC
clbhealingarts.com
clbhealingarts@gmail.com
415-203-6025

Personal Information

Name_____Date_____

Home Address_____

City_____ State_____ Zip_____

Gender_____ Age_____ Date of Birth_____

Relationship Status (Are you married, single, divorced, partnered?)_____

Contact Information

Cell Phone_____ Home Phone_____

Email Address_____

EMERGENCY CONTACT: In case of an emergency, whom would we contact:

Name_____ Relationship_____

Cell Phone_____ Home Phone_____

Employment Information

Occupation_____ Hours of Work_____

Employer_____

Acupuncture Experience

Have you had acupuncture before? (Yes or No)_____

What was your experience like? _____

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Health History

What are your primary complaints/concerns you want treated?

1.

Mark a "X" on scale severity.	When did the condition start?	What treatments have you tried?	What makes it better or worse? (Check and write)
1----------5---------10 (1 for mild, 10 for very severe)			○ heat_____ ○ cold_____ ○ damp_____ ○ exercise_____ ○ rest_____

2.

Mark a "X" on scale severity.	When did the condition start?	What treatments have you tried?	What makes it better or worse? (Check and write)
1-------5-------10 (1 for mild, 10 for very severe)			○ heat_____ ○ cold_____ ○ damp_____ ○ exercise_____ ○ rest_____

3.

Mark a "X" on scale severity.	When did the condition start?	What treatments have you tried?	What makes it better or worse? (Check and write)
1----------5----------10 (1 for mild, 10 for very severe)			○ heat_____ ○ cold_____ ○ damp_____ ○ exercise_____ ○ rest_____

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Medical History

MAJOR INJURIES/TRAUMAS AND SURGERIES

1. _____When? _____

2._____ When? _____

3._____ When? _____

MEDICATIONS/SUPPLEMENTS
(Please list any medications, herbs or supplements that you are presently taking.)

1._____2._____

3._____4._____

5._____6._____

7._____8._____

MAJOR ILLNESS (Please check the "YOU" box if you have or had the condition and note the year it began. Check the "FAMILY" box if there is family history.

Allergies ○ You, When?_____ ○ Family	Anemia ○ You, When?_____ ○ Family	Asthma ○ You, When?_____ ○ Family	Cancer ○ You, When?_____ ○ Family
Diabetes ○ You, When?_____ ○ Family	Drug Addiction ○ You, When?_____ ○ Family	Eating Disorder ○ You, When?_____ ○ Family	Gynecological Disorder ○ You, When?_____ ○ Family
Heart Disease ○ You, When?_____ ○ Family	High Blood Pressure ○ You, When?_____ ○ Family	Kidney Disease ○ You, When?_____ ○ Family	Osteoporosis ○ You, When?_____ ○ Family
Pacemaker ○ You, When?_____ ○ Family	Psychiatric Disorder ○ You, When?_____ ○ Family	Seizure Disorder ○ You, When?_____ ○ Family	Thyroid Disease ○ You When?_____ ○ Family
Hepatitis ○ You, When?_____ ○ Family	Stroke ○ You, When?_____ ○ Family		

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Medical History

Please check symptoms you have now or had in the last year:

Temperature: ○ chills ○ fever ○ aversion to cold ○ aversion to heat ○ hot flashes ○ spontaneous/night sweating ○ lack of sweat ○ thirst, no desire to drink ○ absence of thirst ○ excessive thirst ○ hot hands/feet/chest ○ cold hands and/or feet ○ sensation of heat in bones	Lung Network: ○ wheezing ○ allergies ○ chronic sinusitis ○ frequent/lingering colds ○ cough ○ chest congestion ○ bloodu mucus ○ constant phlegm in chest/throat ○ dry nose/throat ○ shortness of breath Psychoemotional ○ sadness/ grief	Skin and Hair: ○ rashes ○ hives ○ itching ○ eczema ○ lumps/tumors ○ danduff ○ brittle ○ oily ○ dry ○ acne
Heart Network: ○ low blood pressure ○ heart attack ○ palpitations ○ fainting ○ chest pain ○ irregular heart rate ○ hot flushing of face ○ sores on tongue Psychoemotional: ○ anxiety, feeling of dread ○ restlessness ○ depression, no joy ○ insomnia ○ vivid dreams ○ easily startled	Spleen Network: ○ weak muscles ○ prolapse of internal organ(s) ○ poor appetite ○ abdominal bloating ○ loose stools/diarrhea ○ constant hunger ○ bad breath ○ nausea/vomiting ○ heavy sensation ○ pain before or after eating ○ fatigue ○ edema of body Psychoemotional: ○ overly worried, obsessive ○ confused, fuzzy headed	Liver Network: ○ dry, itchy eyes ○ red, swollen, painful eyes ○ cold fingers and toes ○ coarse brittle nails or hair ○ muscle tension ○ vision problems ○ cataracts/glaucoma ○ hypochondriac pain ○ gallstones ○ headaches ○ dizzy, vertigo Psychoemotional: ○ frustration, irritable ○ anger easily
Kidney Network: ○ urinary problems ○ noctouria ○ frequent urination ○ diminished sexual drive ○ swelling in lower extremity ○ ringing in ears ○ weak, sore low back ○ hearing problems ○ thinning of hair ○ genital lesions/discharge ○ lack of sexual secretions Psychoemotional: ○ feeling fearful ○ lack of motiviation	Diet: What do you eat for each meal in general? _____ How often do you eat? _____ Do you feel satisfied after eating? _____ What do eat for snacks? _____ Do you have food allergies? What are they? _____ What are your food cravings?	

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Cancellation Policy_____

Initials

Keeping your appointment is an important commitment to your health. However, if you need to cancel or change an appointment, please be sure to do so 24 hours in advance so that another patient can be accommodated.

All appointments that are rescheduled or cancelled with less than 24 hour advance notice, and appointments missed without notice, will be charged the full fee for your appointment. If appointments have been purchased in a package, the missed, cancelled or rescheduled appointment will be deducted from the number of remaining appointments in that package.

Payment Policy_____

Initials

Payment in full is due at the time services are rendered. If Connie Lock-Bouvier, LAc is out of network with your insurance carrier, a Superbill can be provided. A Superbill is an invoice for your visit that uses standardized codes for all of the treatments performed. This process requires the patient to pay the full cost of the treatment out-of-pocket at the time of the visit. The Superbill can thereafter be submitted to your insurance carrier for full or partial reimbursement depending on your policy. Patients wishing to make use of this service should check with their insurance carriers to be sure that Superbills are accepted and that their plan has acupuncture coverage.

Confidentiality Policy

Your patient records and patient information will be kept confidential and shared only when necessary to provide care and services, by your authorization, or when required or permitted by law.

I understand the confidentiality policy:

_____ _____

Signature Date