Poway Integrative Medicine Center

Dino Guillermo L.Ac

Your Name: _____ Date: _____

Patient Acknowledgement of Financial Responsibility

I, the Patient or legal guardian, understand that my care from Dino Guillermo is on a fee for service basis, and that payment is due at the time service is rendered. If an insurance card is given, I acknowledge that if the patient is determined as "not eligible" under my insurance member provisions and/or any specific procedures are not covered. Financial responsibility for services is mine.

I agree to pay in full for all services rendered within 30 days of receiving a bill from the above noted acupuncturist or any healthcare provider from this group.

I also understand that it is my responsibility to know if my provider is a contracted provider under my health plan and agree to pay any charge incurred as a result of a care received if my provider is not a contracted provider under my specific health plan.

_____
Signature of Patient or Legal Guardian

Appointment Cancellation Policy

In order for us to continue to provide services for all of our patients we need to implement a cancellation policy. This policy states that cancellations must be made 24 hours prior to the scheduled appointment time.

If scheduled appointments are missed or cancellations are not done 24 hours prior to appointment time, we will have to charge you for the appointment. Charges will be a $50 per missed visit. Before rescheduling these charges must be paid.

By signing below, I agree to the above conditions.

_____
Signature of Patient or Legal Guardian

This is CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. If you have question, please ask. Thank you.

Personal Information

Name_____

Home Address_____

City_____ State_____ Zip_____

Home Phone_____ Email_____ Work Phone_____

Occupation_____ Person Responsible for your account_____

Emergency Contact: Name_____ Phone _____

Who should we thank for referring you to this office? _____

Sex: ☐ Male ☐ Female ☐ Trans ____MTF _____FTM

Height _____ Weight_____ Birthday_____ Age _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnered

Do you have children? ☐ Yes ☐ No If so, how many? _____

Have you received acupuncture therapy before? ☐ Yes ☐ No

If so, when? _____ With whom? _____

Please indicate any significant illness you or a blood relative (Grandparent, parent or sibling) have had:

Illness	***You***	***Your Relative***	***Approx Date***	***Illness***	***You***	***Your Relative***	***Approx Date***
Cancer	☐	☐	☐	Diabetes	☐	☐	☐
Hepatitis	☐	☐	☐	Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐	Seizures	☐	☐	☐
Rheumatic Fever	☐	☐	☐	Emotional Disorders	☐	☐	☐
Infectious Diseases	☐	☐	☐	Tuberculosis	☐	☐	☐

Sexually Transmitted Disease: ☐ Gonorrhea ☐ Syphillis ☐ Hiv ☐ Chlamydia ☐ Herpes

List any medications and supplements you are currently taking: (Continue on back if necessary)

Name of Medicine	***Dose***	***Reason***	***How long you've been taking it for***	***Prescribed by***	***Date of last check-up***
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Check the Box if any of the following statements are true:

☐ I have known allergies ☐ I am taking Coumadin/Warfarin

☐ I have a pacemaker ☐ I am taking Lithium (Eskalith, Lithobid, Lithonate, Lithotabs)

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much		Yes	No	How much
Coffee/black tea	☐	☐	_____	Tobacco	☐	☐	_____	Water Intake	☐	☐	_____
Non-medical drugs	☐	☐	_____	Alcohol	☐	☐	_____	Soda pop	☐	☐	_____

What are the main health problems for which you are seeking treatment?

_____

_____

_____

What other forms of treatment have you sought? _____

_____

_____

List any other health problems you now Have: _____

_____

_____

List any allergies, food sensitivities or food craving that you have:

_____

_____

_____

List any accidents, surgeries, or Hospitalizations (include date):

_____

_____

_____

Lab results (please include copies):

_____

_____

_____

Clinical Notes
(Intern's Use)

HPI:

- ☐ Onset
- ☐ Location
- ☐ Duration
- ☐ Characteristics
- ☐ Aggravate/allev
- ☐ Related factors
- ☐ Treatment
- ☐ Significance

How do you FEEL about the following areas of your life?

Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Your Comments
Significant other	☐	☐	☐	☐	☐	_____
Family	☐	☐	☐	☐	☐	_____
Diet	☐	☐	☐	☐	☐	_____
Sex	☐	☐	☐	☐	☐	_____
Self	☐	☐	☐	☐	☐	_____
Work	☐	☐	☐	☐	☐	_____
Exercise	☐	☐	☐	☐	☐	_____
Spirituality	☐	☐	☐	☐	☐	_____

Other information you would like to report/may relevant to your medical history:

_____

_____

Symptom Survey

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:

No mark = never experience Check mark = sometimes experience Plus Sign = frequently experience

____ Lack of appetite
____Excessive appetite
____Loose Stool or diarrhea
____ Digestive problems indigestion
____Vomiting
____ Belching, burping
____ Heartburn/reflux
____ Feeling the retention of food in the stomach
____ Tendency to become obsessive in work, relationships….
____ Insomnia, difficulty sleeping
____ Heart palpitations
____ Cold hands and feet
____ Nightmares
____ Mental restless
____ Laughing for no apparent reason
____ Angina pains
____ Abdominal pain
____ Chest pain
____ Sciatic pain
____ Headaches
____ Pain or coldness in the genital area
____ Cough
____Shortness of breath
____ Decreased sense of smell
____ Nasal problems
____ Skin problems
____ Feeling of claustrophobia
____ Bronchitis
____ Colitis or diverticulitis
____ Constipation
____ Hemorrhoids
____ Recent use of Antibiotics
____ Eye problems
____ Jaundice (yellowish eyes or skin)
____ Difficulty digesting oily foods
____ Gall stones
____ Light colored stool
____ Soft or brittle nails
____ Easily angered or agitated
____ Difficulty in making plans or decisions
____ Spasms or twitching of muscles
____ Low back pain
____ Knee problems
____ Hearing impairment
____ Ear ringing
____ Kidney stones
____ Decreased sex drive
____ Hair loss
____ Urinary problems
____ Fatigue
____ Edema
____ Blood in stool
____ Easily bruised
____ Difficult to stop bleeding
____ Asthma
____ Tendency to catch colds easily
____ Intolerance to weather changes
____ Allergies
____ Hay fever
____ Dizziness
____ Tendency to faint easily
____ High Cholesterol levels
____ Sudden weight loss

Poway Integrative Medicine Center
Consent to Treatment Form

By signing below, I do herby voluntarily consent to be treated with acupuncture and/or herbs, supplements and other substances from the Oriental Materia Medica by a licensed acupuncturist at Poway Integrative Medicine Center.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to the acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from it use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological function. I understand that I am not required to take these substances but must follow the direction for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call the prescribing physician as soon as possible.

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Elector-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my acupuncturist for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ Date: _____
Printed Name: _____ Date of Birth: _____
Address: _____
City: _____ State: ____ Zip Code: _____ Phone: _____

Sign Below only if you requested and received more detailed information

I requested and received, in substantial detail, further explanation of the procedure or treatment other alternative procedures or methods of treatment and information about the material risks of the procedure of treatment. I give my permission and consent to treatment.

X _____ X _____
Patient's Signature Date Explained to me and signed in my presence Date