CONFIDENTIAL

Today's Date: _____

Tracy Ng, L.Ac., DAOM
2716 Ocean Park Blvd, Suite 2007
Santa Monica, CA 90405
Phone: 310.393.3012
Email: tracy.ng@mac.com

PATIENT BILLING AND CONTACT INFORMATION

NAME_____

IF PATIENT IS A MINOR, PARENT'S NAMES_____

BIRTHDATE_____ AGE _____ SEX _____ MARITAL STATUS _____

MAILING ADDRESS_____

_____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ FAX NUMBER _____

EMAIL ADDRESS _____

OCCUPATION_____

EMPLOYED BY_____

SUPERVISOR NAME_____

EMPLOYER ADDRESS_____

EMPLOYER PHONE_____

WHO IS RESPONSIBLE FOR PAYMENT ON THIS ACCOUNT?_____

WHERE SHOULD BILLS BE SENT?

NAME_____

ADDRESS_____

PHONE NUMBER_____

WHO MAY WE THANK FOR YOUR REFERRAL?_____

IN CASE OF EMERGENCY, WHO MAY WE CONTACT?

NAME_____ PHONE NUMBER _____

RELATIONSHIP_____

Tracy Ng, L.Ac., DAOM
2716 Ocean Park Blvd, Suite 2007
Santa Monica, CA 90405
Phone: 310.393.3012
Email: tracy.ng@mac.com

OFFICE POLICIES AND FINANCIAL AGREEMENT

The fees for office services, supplements and support are payable in full at the time of your visit, unless other arrangements have been made. The fees charged in this office are comparable to those charged by other specialists with similar qualifications in this area.

If it is necessary for you to cancel or reschedule an appointment, we require a FULL 24 HOURS NOTICE to change your appointment without charge. *Any appointments canceled or rescheduled without 24 hours notice will be charged for a full office visit.* Please realize that we have reserved this time for you and that another person in need of care will be able to have time with the doctor when 24 hours notice is given. Please note that if you are more than 20 minutes late for your appointment, we may not be able to accommodate you.

Please understand that we have no payment agreements with your insurance companies. Insurance benefits are a matter between you and your insurance company. We will be happy to supply you with any information you may need to assist you in procuring payment of your medical claims. Submission of medical insurance claims is the responsibility of the insured.

If you are a patient who has had a non-work-related accident, automobile, or other injury, it is your responsibility to provide us with the name and address of both the responsible insurance companies and that of your attorney.

We reserve the right to make a finance charge at an interest rate of 1.5% per month for every month that your account remains overdue after 30 days.

I have read, understand, and agree to the above policies.

Name (Print)_____

If patient is a minor, name of child for whom I am the parent or legal guardian_____

Signature_____Date_____

INFORMED CONSENT

Tracy Ng, L.Ac., D.A.O.M. is a Licensed Acupuncturist and Doctor of Oriental Medicine. Dr. Ng is not a medical doctor. She does not claim to diagnose, treat, cure, or prevent any medical conditions or pathologies, nor prescribe medicine, nor in any way represent herself as doing so. The services of a Doctor of Oriental Medicine cannot replace those of a licensed physician. For any medical condition, you are advised to seek care from an appropriate medical practitioner. It is your right whether you choose to engage a medical practitioner or not to assist you in your care, and Dr. Ng assumes no responsibility for your decision in this matter.

I, the undersigned, assume all responsibility for decisions I make regarding my health, recognizing that (a) no claims are made that acupuncture, herbal, nutritional, or dietary recommendations can treat or cure any medical condition, (b) all recommendations are given for informational purposes only, (c) there is no implied or stated guarantee of success of effectiveness of any specific acupuncture, dietary, nutritional, or herbal recommendations, (d) I am free to act upon or disregard the recommendations of Tracy Ng, L.Ac., D.A.O.M. as I so choose. I hereby release Dr. Tracy Ng and the Office of Tracy Ng, D.A.O.M. from all responsibility for my actions and any consequences thereof in the present time and in the future with no constraints. I hereby affirm that I consent and agree to the above statements of my own free will and request to engage in the services offered by Tracy Ng, L.Ac., D.A.O.M. and participate in a professional relationship with her pursuant to the statements herein.

Name (Print)_____

If patient is a minor, name of child for whom I am the parent or legal guardian_____

Signature_____Date_____

PRIVACY PRACTICES ACKNOWLEDGMENT

I have received or have been provided an opportunity to review a copy of the Notice of Privacy Practices.

Name _____ Signature _____ Date _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message for appointment reminder calls
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message for appointment reminder calls
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number_____

☐ Email_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.
Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom, Address or Fax Number	Purpose of Disclosure	By Whom Disclosed	T=Tx Records P=Payment Info	F=Fax E=Email M=Mail

Tracy Ng, L.Ac., DAOM
2716 Ocean Park Blvd, Suite 2007, Santa Monica, CA 90405
Phone: 310.393.3012

PATIENT NAME

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 1 OF 2 - PLEASE SIGN BOTH SIDES

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated**: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, and procedural disputes will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: **General Provision**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: **Revocation**: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: **Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE (Or Patient Representative) X (Date) (Indicate relationship if signing for patient)

PLEASE SIGN REVERSE SIDE ALSO

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 2 OF 2 - PLEASE SIGN BOTH SIDES

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental massage), Oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do *not* expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

PATIENT SIGNATURE X Date
(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE Date

PLEASE SIGN REVERSE SIDE ALSO

CONFIDENTIAL MEDICAL HISTORY **DATE**_____

NAME_____AGE_____M_____F_____

DATE OF BIRTH_____MARITAL STATUS_____Height_____Weight_____

Name of Family Physician_____

Occupation_____Referred by_____

INSTRUCTIONS: In order to carefully evaluate your condition(s) and acquire a thorough overview of you as a unique individual, please take the time to thoughtfully complete this extensive questionnaire, so that an individualized treatment plan can be developed.

PRIMARY REASON(S) AND GOAL(S) FOR YOUR VISIT AND TREATMENT?

_____

_____

Have you previously been treated by: _____Acupuncture _____Herbal Medicine _____Nutritional Therapy
_____Homeopathy _____Chiropractic? Name(s) of Practitioners_____

FAMILY HISTORY	Self	Mother	Father	Brother	Sister	Grand-parents	Comments
Alive? (Yes/No)	Y						
In Good Health? (Y/N)							
Arthritis/Gout							
Asthma							
Allergies							
Cancer (what type?)							
Diabetes							
Epilepsy/Seizures							
Heart Disease							
Hepatitis A,B,C, other							
High Blood Pressure							
Thyroid Disease							
Kidney Disease							
Emotional Disorders							
Stroke							
Ulcers							
Tuberculosis							
Bleeding Disorders							
Weight Problems							

PLEASE CHECK ANY OTHER ILLNESS WHICH YOU HAVE HAD

___Anemia
___eczema
___Psoriasis
___Bronchitis
___Emphysema
___Diverticulitis
___Colitis
___Hepatitis
___Hernia
___Fibromyalgia
___Eye disease
___Gall stones
___Malaria
___Liver disease
___Typhoid fever
___Yeast infection
___Jaundice
___Pancreatitis
___Migraines
___Epstein Barr Virus
___Mononucleosis
___Polio
___Rheumatic fever
___Chicken pox
___Measles
___Mumps
___Hemorrhoids
___Parasites
___Chronic fatigue syndrome

Sexually transmitted diseases
___Herpes
___Gonorrhea
___Syphilis
___HIV
___Genital Warts, HPV
___Other

Tracy Ng, L.Ac., DAOM
2716 Ocean Park Blvd , Suite 2007, Santa Monica, CA 90405
Phone: 310-393-3012

DIAGNOSTIC TESTS, PLEASE NOTE YEAR IF KNOWN

X-Ray/Ultrasound	CT-Scan/MRI	
___Chest	___Brain	___Mammogram
___Kidney	___Bone	___Bone Density(osteoporosis screen)
___Upper G.I.	___Spine	___PAP Smear
___Lower G.I.		___Prostate Exam
___Gallbladder	___EKG electrocardiogram	___Blood Profile
___Sinus	___EEG electroencephalogram	___Urine Test
___Bone	___TB Skin Test	___Hearing Test
___Spine	___Thyroid Tests/Exam	___Eye Exam

Please name physicians and practitioners you are currently seeing or have seen in the past two years

Name	*Reason for visit*	*Date or Age*

Please list past major illnesses, accidents, injuries, surgeries, and hospitalizations Date or Age

Current Prescriptions or Over-the Counter Medications

Past use of antibiotics or steroids (prednisone, cortisone, etc.):

Current Vitamins, Herbal, Homeopathic and Natural Medicines

Are you now or have you ever taken any of the below?

___Birth Control Pills	___Sedatives or Sleeping Pills	___Pain Medication
___Estrogen or Progesterone	___Thyroid Medication	___Chemotherapy
___Cortisone or other Steroids	___Allergy Shots	___Blood Pressure Medication
___Anti-depressant Medication	___Antihistamines	___Cholesterol Medication
___Anti-anxiety Medication	___Antibiotics	___Other

PLEASE LIST ANY KNOWN ALLERGIES (food, drugs, pollens, dust, etc.)

Tracy Ng, L.Ac., DAOM
2716 Ocean Park Blvd , Suite 2007, Santa Monica, CA 90405
Phone: 310-393-3012

LIFESTYLE

Do you currently smoke cigarettes?_____ Do you want to quit?_____
Have you ever smoked cigarettes?_____ For how long?_____ Packs per day_____
Recreational drug use_____past_____present History of IV use ___yes ___no
Do you drink alcohol?_____How often?_____Type?_____
Do you drink _____coffee_____black tea_____decaf_____regular Cups per day
Amount of time spent outside daily_____Hours per day on sitting or on computer_____
How often do you exercise?_____Type of exercise_____
What do you do to unwind and relax?_____How often?_____
Meditation_____Yoga_____Martial Arts_____Cardiovascular exercise_____Weight training_____.
Stretching_____

DIET & FOOD **Please circle all that apply**

___Weight Fluctuations ___Overeating ___Frequent Dieting ___Vomit after eating
___Anorexia ___Bulimia ___Food Binges ___Use of diet pills/ appetite suppressants

___Satisfied ___Dissatisfied with current bodyweight

What do you usually eat for:

Breakfast_____

Lunch_____

Dinner_____

Snack_____

Do you typically ____eat out____eat home cooked meals?

Are you on a special diet? Why? Describe_____

CRAVINGS (please mark C) or Food Aversions (please mark A)

___Salty	___Sour	___Starches	___Spicy	___Oily/Fatty
___Milk/Dairy	___Sweets	___Breads/Pastas	___Chocolate	___Eggs
___Iced/cold foods	___Warm Foods	___Other		

SYMPTOMS: Please circle any that have bothered you in the past 6 months. Please comment if you have noticed timing of onset, frequency, duration, patterns, etc.

HEAD

Headaches	Sore scalp/dandruff	Dizziness	Hair loss

EYES

Dry eyes	Inflamed eyes	Swelling or pain	Dark circles
Excessive tearing	Double vision	Eyeglasses	Puffiness
Light sensitivity	Blurred vision	Contact lenses	Eye surgery
Ear pain	Ear ringing	Ear discharge	Dizziness
Poor hearing	Deafness	Loss of Balance	

Tracy Ng, L.Ac., DAOM
2716 Ocean Park Blvd , Suite 2007, Santa Monica, CA 90405
Phone: 310-393-3012

NOSE

Poor sense of smell	Post nasal drip	Sensitivity to:	
Frequent colds/flus	Frequent bloody nose	Dust	Animal hair
Hay fever/Allergies	Sinus pain	Molds	Chemical fumes
Sinus Infection	Sores in Nose	Pollens	Pesticides
Nasal obstruction	Runny nose	Perfumes	

MOUTH

Bleeding gums	Oral herpes (Cold Sores)	Dental cavities	Ulcers in mouth
Dry lips	Dry mouth	Dentures	Sore tongue

THIRST

Normal thirst Rarely Thirsty Excessive Thirst

Please check drink preference ___HotCold ___Iced___Room Temperature

RESPIRATORY

Sore throat	Spitting up mucus often	Bronchitis	Blood in sputum
Difficulty swallowing	Hoarseness	Thick sputum	Pain with breathing
Tonsillitis	Cough	Wheezing	Shortness of breath
Sensation of something is caught in throat			

CARDIOVASCULAR

Chest pain	Leg cramps at night	Cold hands or feet	Shortness of breath
Tightness in chest	Leg cramps when walking	Heart attack	Swollen ankles/feet
Heart palpitations	Bruise or bleed easily	Stroke	Heart murmur
Difficulty lying flat	Varicose veins	High cholesterol	Mitral valve prolapse
Rheumatic fever	Wounds infected easily or heal slowly	Irregular heart beat	

SKIN

Rash	Itching	Herpes	Warts
Pigment changes	Abnormal sweating	Acne with stress	Skin or nail fungus
Dryness	Eczema	Acne with menstruation	Psoriasis

GASTROINTESTINAL

Poor appetite	Poor digestion	Food allergies	Spit up blood
Pain with eating	Nausea	Belching	Hypoglycemia
Excessive appetite	Heartburn	Ulcers	Difficulty swallowing
Intestinal gas/bloating	Vomiting	Sleepy after eating	Gallbladder problems
Diarrhea	Loose or watery stool	Undigested food in stool	Black or tarry stools
Constipation	Dry hard stool	Blood in stool	Hemorrhoids
Mucus in stool	Hernia	Use laxatives often	Inflammatory bowel disease

How often do you have a bowel movement?_____

Tracy Ng, L.Ac., DAOM
2716 Ocean Park Blvd , Suite 2007, Santa Monica, CA 90405
Phone: 310-393-3012

URINARY

Frequent bladder infections___with intercourse___with stress

Frequent urination	Loss of force of urine stream	Pus in urine
Urge to urinate at night	Pain or burning with urination	Blood in urine
Urination with cough or sneeze	Retention of water/fluids	Sand/gravel in urine
Hesitancy of urination	Hands or ankles swell easily	Change in quantity of urine

Color of Urine: ___clear___straw___yellow other_____How often do you urinate each day?

REPRODUCTIVE

Decreased sexual desire	HIV	Infertility	Sexual Orientation:
Gonorrhea	Trichomonads	Celibate	Heterosexual
Herpes	Chlamydia	Multiple Sexual Partners	Gay/Lesbian
Syphilis	Genital Warts (HPV)		Bisexual

MEN ONLY

Burning or Discharge from Penis	Anal Sex	Seminal Emission
Low Sperm Count	Male Sexual Partners	Premature Ejaculation
Prostate Surgery	Prostate Infection	Pain or Coldness in Genital Area
Prostate Inflammation	Prostate Enlargement	Swelling or Lumps in Testicles

Difficulty in Achieving or Maintaining an Erection

Method of Birth Control_____

Frequency of Intercourse_____

Date of Last Prostate Exam_____

Have you had a PSA test (blood test screen for prostate cancer)?_____Date_____

WOMEN ONLY

Vaginal Pain	Vaginal Sores	Infertility	Discharge from Nipples
Vaginal Dryness	Vaginal Itching	Ovarian Cysts	Breast Lumps or Cysts
Vaginal Discharge	Pelvic Infection	Uterine Fibroids	Breast Tenderness
Vaginal Infections	Painful Intercourse	Endometriosis	

Frequency of Intercourse?_____

Do you practice regular breast self exam?_____

Date of last mammogram_____

Date of last PAP test and pelvic exam_____

Personal or Family history of Cancer? ____Breast_____Ovarian_____Cervical

Menstruation & Pregnancy

No Menstrual Period	Premenstrual Bloating	Heavy Blood Flow	Light Blood Flow
Irregular Periods	Menstrual Cramps/Pain	Clots in Blood	Spotting Between Period

If you have Premenstrual Syndrome, please describe _____

_____Age of first period_____How many days apart are your periods?_____

How many days do you flow?_____

Number of pregnancies_____Number of abortion_____Number of miscarriages _____ Number of live births_____Are you or might you be Pregnant?_____

Fertility treatment? Describe_____

Cesarean Section?_____Complications with pregnancy, labor, or delivery?_____

Birth Control Method. Current_____Past_____

Menopause Age or year when menstrual cycles ceased_____

Currently Menstruating?_____How Often?_____Changes in cycle_____

Hormone Replacement Therapy?_____Drugs or Herbal Medicines_____

Hot Flashes_____Night Sweats_____Change in Sex Drive_____

Change in Mood? Describe_____Change in Sleep?_____

_____Other_____

Have you had a bone density scan (for osteoporosis)?_____Date_____Results_____

Tracy Ng, L.Ac., DAOM
2716 Ocean Park Blvd , Suite 2007, Santa Monica, CA 90405
Phone: 310-393-3012

ENDOCRINE/IMMUNOLOGIC

Diabetes	Hypoglycemia	Infertility	Fatigue
Abnormal Weight Gain	Abnormal Weight Loss	Night Sweats	Unexplained fever or chills
Frequent Low Grade Fever	Loss of feeling of well-being	Depression	
Neck Enlargement	Hair or Nail Changes	Intolerance ___to heat ___to cold ____to wind	
Dry Skin	Fluid Retention	Perspiration ____excessive ____diminished	

MUSCULOSKELETAL

Arthritis Muscle Spasm Swelling Stiffness Sciatica Disc Injury Scoliosis Osteoporosis

Check Location of Pain Below/ Describe_____

___Foot ___Ankle ___Knee ___Leg ___Hip ___Shoulder ___Elbow ___Wrist ___Arm ___Hand

___Head ___Neck ___Spine ___Jaw Other_____.

NEUROLOGIC

Nervousness	Shaking seizures	Drowsiness	Loss of sensation
Dizziness	Convulsions	Memory changes	Changes in handwriting
Numbness	Loss of coordination	Fainting	Nerve pain
Tremors	Paralysis	Muscular weakness	

SLEEP

Insomnia Difficulty Staying Asleep Wake up Often at Night/At What Time?

Difficulty Falling Asleep Disturbing Dreams/Nightmares

Position you sleep in_____Usual Bedtime_____ Usual Waking Time_____

WORK

Type of work/profession_____Number of hours worked daily_____

I spend much of the day ___Sitting ___Standing ___Lifting ___On the Phone ___Heavy Physical Work

I find my work ___Fulfilling ___Enjoyable ___Boring ___Frustrating ___Stressful ___Exhausting

CONTINUED ON NEXT PAGE

Tracy Ng, L.Ac., DAOM
2716 Ocean Park Blvd , Suite 2007, Santa Monica, CA 90405
Phone: 310-393-3012

STRESS/EMOTIONS

What are the sources of stress in your life now?_____

My ability to cope with stress is _____Poor _____Fair _____Good _____Excellent

I am under the care of a ____Psychotherapist____Psychiatrist

I am currently taking medication for___mood___sleep___pain

Please note those feelings that describe your tones, qualities, tendencies and experiences in the last 12 months.

Frequent stress	Loss of mental clarity	Relaxed	Death of a loved one
Mood swings	Feeling hostile	Fulfilled	Spiritual
Loss of well-being	Unusual tension	Content	Religious
Listless/lethargic	Angry outbursts	Optimistic	Philosophical
Undue fatigue	Frustrated	Motivated	Introspective
Difficulty with decisions	Irritable	Inspired	Expressive
Withdrawn	Frequent crying	Joyful	Tend to be social
Lonely/isolated	Sadness	Daytime sleepiness	Tend to be a loner
Nervous/anxious	Despair	Disturbing dreams	Alcoholism
Overwhelmed	Grief/loss/sorrow	Insomnia	Substance abuse
Pressured	Disappointment	Worried by little things	Eating disorder
Conflicted	Hopelessness	Perfectionist	Weight problems
Shaky	Depression	High achiever	Comfortable with myself
Fragile	Suicidal thoughts	Very sensitive	
Easily offended	Self-critical	Change in marital status	
Poor concentration	Critical of others	Change in residence	
Memory Changes	Unhappy	Change in work/job	

TOXIC EXPOSURES Please Circle All that Apply.

Lead	Radiation	Tobacco	Asbestos	Chemical Fumes	Chemotherapy
Uranium	Pesticides	Herbicides	Mercury(silver-mercury dental fillings)		Other

TIME OF DAY/CLIMACTIC FACTORS

What hour(s) of the day do you feel at your best?_____AM _____PM

At your worst?_____AM _____PM

Please specify (B) for Better or (W) for Worse

Season/months of the year ____Spring____Summer ____Fall ___Winter

Do you feel Better or Worse ____Work ____Home ____Inside ___Outdoors

Climate: Better or Worse ____Dry ____Hot Cold ____Snow ___Damp ____Rain

List the health issues that concern you most, in order of importance

1,_____2._____

3._____4._____

Tracy Ng, L.Ac., DAOM
2716 Ocean Park Blvd , Suite 2007, Santa Monica, CA 90405
Phone: 310-393-3012

In your opinion, what are the primary factors contributing to the onset and continuation of your illness or loss of well-being?

What do you feel will help you to achieve your goals? How long do you expect the process to take?

Thank you for taking the time to fill out this questionnaire. Your answers will allow for the development of a unique treatment plan not only for symptomatic treatment, but also for holistic healing.

Health is more than the absence of disease. Health is conscious living focused on wellness of the mind, spirit, and body.

Tracy Ng, L.Ac., DAOM
2716 Ocean Park Blvd , Suite 2007, Santa Monica, CA 90405
Phone: 310-393-3012