New Patient Intake

Five Branches University

Clinic of Traditional Chinese Medicine

Santa Cruz:
200 Seventh Ave, Ste. 115, Santa Cruz, CA 95062
PH: (831) 476-8211 Fax: (831) 476-8088

San Jose:
1885 Lundy Ave, Suite 108, San Jose, CA 95131
PH: (408) 260-8868 Fax: (408) 260-8889

*Welcome to the Five Branches University. To help us provide you with the best possible care, please fill out this form as accurately as possible **using Black Ink ONLY please**. All the information will be kept confidential.*

Name: _____
First Middle Last

Address: _____
Street City State zip code

Home Phone: (_____) _____ Work or Cell Phone: (_____)_____

Would you like to receive appointment reminders via text message ? ☐Yes ☐No
Please circle one

Birth Date: _____/_____/_____ Age: _____ E-Mail: _____
MM DD YY *We do not share email addresses with any outside parties.*

Marital Status: _____ Gender: _____ Occupation: _____

In case of emergency, contact: _____ _____ _____
Name Relationship Telephone

How did you hear about us? _____

Do you have Medi-Cal? ☐Yes ☐No (Central California Alliance *only*)

Do you have Private Insurance? ☐Yes ☐No If yes, please fill out Insurance Verification Form

Office Policy:

All fees for medical services are due at the time of visit unless arrangements have been made between Five Branches and your insurance company. Five Branches Clinic will bill for insurances that cover Acupuncture. I understand that I am fully responsible for my bill and that if attempts to collect payment from my insurance company/responsible party are not successful, I will remit the balance due in full upon notification. Please note that all published prices reflect a courtesy discount for cash patients.

Cancellation Policy:

If you need to cancel an appointment, please give us a minimum of 24 hours notice. We assess a cancellation fee for less than 24 hour notification.

◆ My signature authorizes the Five Branches University Clinic to treat me (or the patient for whom I am legally responsible) with acupuncture and Chinese medicinal herbs within the license 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 judgment 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 Five Branches University Clinic Notice of Privacy Policies.

Signature: _____ Date: _____

(Patient, Parent or Guardian)

Medical History: Check all boxes below that are now or have been part of your personal health history.

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

Chief Complaint: Please describe your chief health concerns and other relevant information not mentioned above.

Are you being treated elsewhere? ☐Yes ☐No

For what complaint? _____

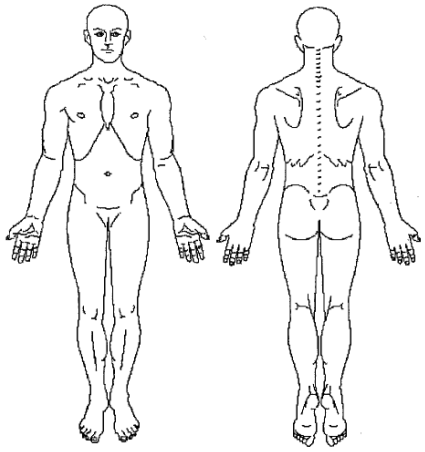
Personal Physician:_____
Name

Are you currently using prescription or herbal medicines? ☐Yes ☐No

If yes, please list: _____

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	❑ Vitamins/Supplements	❑ Special Diet specify below:



Please indicate with an X any areas of pain or injury:

❑ Constant vs ❑ Intermittent

❑ Sudden Onset vs☐ ❑ Gradual Onset

❑ Sharp vs ❑ Dul

❑ Numbness ❑ Tingling

❑ Swelling/Edema ❑ Burning

❑ Bruising/Tenderness ❑ Radiating to_____

❑ Spasms/Tremor ❑ Stiffness