WELCOME!

I recognize that your choice to experience Chinese Medicine and Integrative Care is based on your interest for optimal health. Below you will find detailed information regarding your New Patient Visit. My goal is to enhance your health and wellbeing today and into the future. I look forward to forming a long-lasting partnership with you.

When making your appointment, be sure to specify if this is for an ACUTE condition. If you need to reschedule your appointment we would appreciate 24 hours advance notice.

ACUTE HEALTH CONDITIONS

(injury/trauma, cold/flu, food poisoning, bell's palsy, etc.)

It is necessary to arrive at your appointment at least 20 minutes ahead of time to fill out all paperwork. Arriving late will take away from time for your diagnosis and treatment.

WHAT TO EXPECT AT YOUR FIRST APPOINTMENT:

Please allow approximately 90 minutes for your appointment. This will include time for both diagnosis and treatment. I will spend approximately 30 minutes with you going over the history of your current symptoms. This can include orthopedic examination for musculoskeletal injuries, detailed questioning, and classical pulse and tongue diagnosis. Following evaluation, I will perform a treatment. This will likely include several of the following: acupuncture, gua sha, cupping, massage, joint-mobilization, and therapeutic exercises.

In some cases, you may be suffering from an injury that has been previously treated by your primary care physician or an orthopedic specialist. If your injury has been evaluated, and you had x-ray or MRI imaging performed, it is often helpful to have those images or reports forwarded to me for review. Please bring any imaging with you to your appointment or, if you prefer, you can have your treating physician send these records (including their chart notes) to me directly. If you choose this option you will need to use the form labeled, "Request for Medical Records" in this packet. Please note, it is your responsibility to confirm the appropriate files are forwarded to my office.

You can send your records to:

1. By email: JustinEhrlichLAc@gmail.com
2. By Mail: 4443 30th Street, Suite 210, San Diego, CA 92116

GENERAL OFFICE POLICIES:

Please initial where indicated to signify agreement with our policies:

Pre-Treatment Considerations: Please eat an adequate amount of food before your treatment. You should not receive acupuncture with an empty or overly full stomach. As with any medical procedure, you should not consume alcohol or any other intoxicating substance before your treatment.

Post-Treatment Care: If you receive treatments for pain, avoid aggravation of the painful area between treatments. It is recommended to "baby" that area and avoid strenuous or aggravating activity as much as possible in order to receive maximum benefits. If the area is constantly aggravated, it will take more treatments to achieve satisfactory results.

Timing: I encourage my patients to arrive early so that you can use the restroom, have a drink of water and relax for a few minutes before your treatment. I do my best to be on time for all of our appointments. If circumstances cause you to be late for your appointment, please be advised that your visit will need to be shortened so that other patients are not kept waiting. Please allow about one hour for acupuncture treatment.

Phone Calls/Emails: Open communication is essential and allows you to express any concerns. Please call or email me regarding unexpected side effects from treatment, or questions about your herbal medicines or nutraceuticals. I normally set aside 5 minutes for these complimentary communications. If you wish to have a more lengthy phone consultation before your next visit, you may schedule a phone appointment in 15-minute increments at my regular hourly rate.

Insurance: Full payment for services is due at the time of your visit. However, some insurance companies do cover acupuncture treatments. I suggest that you contact your carrier regarding your individual benefits. As a courtesy, I can offer you a itemized-receipt for services, which you may submit to your carrier or flexible-spending account for direct reimbursement. _____ ***(initial)***

Cancellations: Your scheduled appointment time reserves exclusive time with me. Missed appointments and late cancellations are wasted time that cannot be spent with another patient. I understand that circumstances arise which may require you to change your appointment time.

If you need to reschedule, please notify me at least 24 hours in advance to avoid being charged the full rate of your scheduled visit. _____ ***(initial)***

New Patient Information

Name: _____ Date: _____

Age: _____ M / F Date of birth: _____ Birthplace: _____

Height: _____ Weight: _____

Address: _____

_____

Phone # (home)_____ (work) _____ (mobile) _____
(Please circle the best phone number to reach you)

Email address: _____ SSN: _____

Occupation: _____ Hours per week: _____

Marital status: _____ Number of Children: _____

Emergency contact: _____ Phone #: _____

Primary Care Physician: _____

Other Treating Physicians: _____

Health Insurance and ID/Group Numbers: _____

Referred by: _____

Have you been treated by an acupuncturist before? _____

If so, name of acupuncturist and conditions treated: _____

Primary health concerns and goals:

_____

_____

_____

_____

_____

Other concerns (list as many as you like, in order of importance to you):

_____

_____

_____

_____

_____

In your opinion, what are the primary factors that caused your symptoms? What is keeping you from healing? If you have an injury, please describe what happened and how it occurred.

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

Is there anything you would not be willing to change in your life? _____

_____

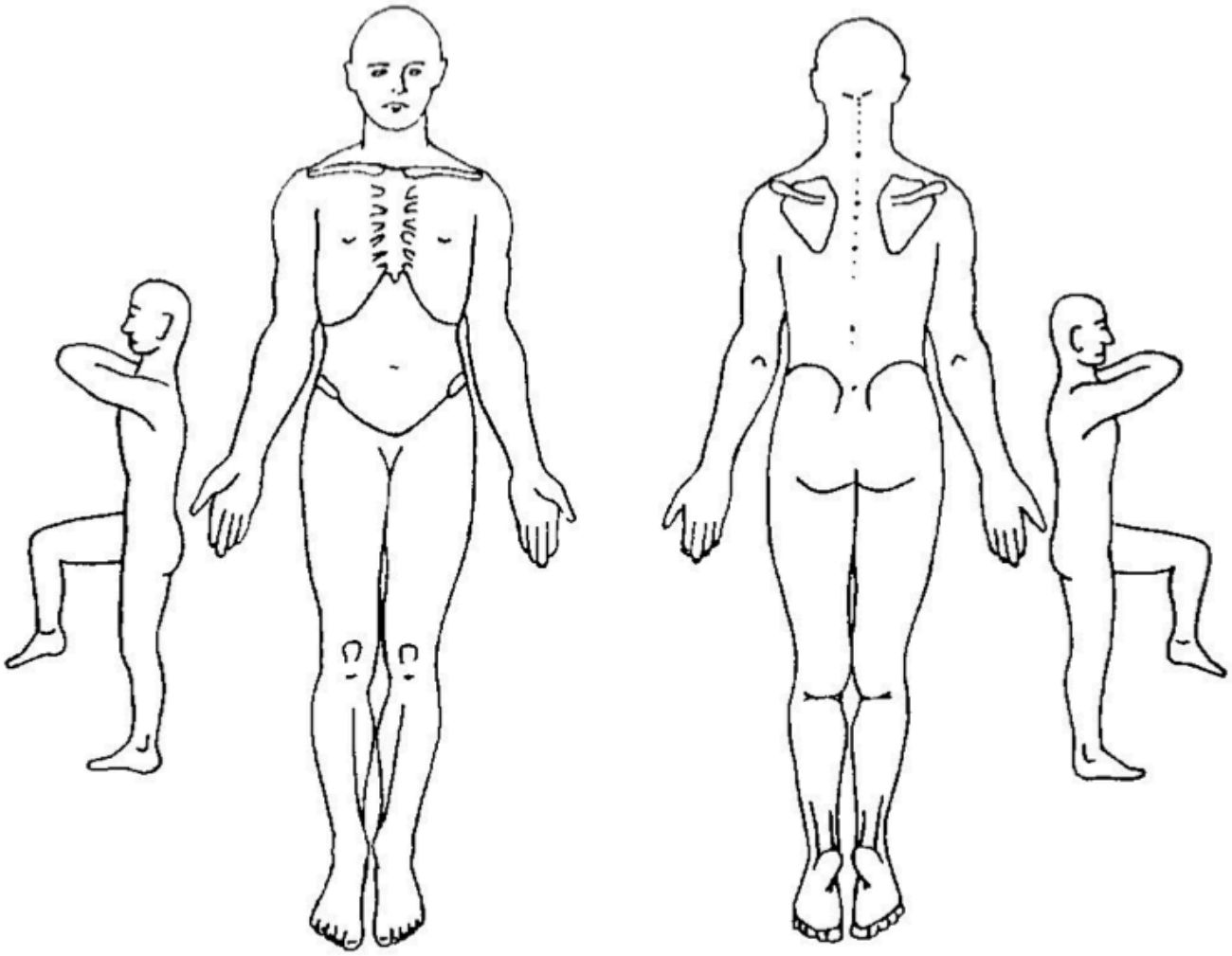
_____

_____

CURRENT PAIN SYMPTOMS

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates/spreads with a ↑, ↓, ←, → to indicate the direction of the radiating pain.

A = Ache	**D = Dull Pain**	**O = Other, please describe**	**R = Radiating Pain**
B = Burning Pain	**N = Numbness**	**P = Pins & Needles**	**S = Stabbing Pain**



Please indicate how you would rate your pain in each area on a 1-10 scale.

Is there any more information about your pain or injury that you feel I should know? _____

_____

_____

WORK:

Type of Work/Profession: _____ Hours Worked Daily? _____

I spend much of the day: ☐ Sitting ☐ Standing ☐ Lifting ☐ On the phone ☐ Heavy Labor

I find my work: □ Boring □ Challenging □ Enjoyable □ Exhausting
□ Frustrating □ Fulfilling □ Pressured □ Stressful □ Other _____

STRESS/EMOTIONS:

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

_____

_____

_____

My ability to cope with stress is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

I am under the care of a: ☐Psychotherapist ☐Psychiatrist

I am taking medications for: ☐Mood ☐ Sleep ☐ Pain

Are there areas in your life where you feel disempowered, powerless, or a victim? If so, please explain why.

_____

_____

_____

_____

Do you have frequent mood changes? If so, please indicate the specific moods and if you know the reasons why:

_____

_____

_____

_____

FAMILY HISTORY	Self	Mother	Father	Brother	Sister	Grandparents	Comments
Alive? Yes/No?		Y N	Y N	Y N	Y N	Y N	
In Good Health?	Y N	Y N	Y N	Y N	Y N	Y N	
Arthritis/Gout?							
Asthma							
Allergies							
Bleeding Disorders							
Cancer							
Diabetes							
Eating Disorders							
Emotional Disorders							
Epilepsy							
Heart Disease							
High Blood Pressure							
Kidney Disease							
Stroke							
Thyroid Disease							
Tuberculosis							
Ulcers							
Weight Problems							
Other Significant Illneses							

Please check any other illness you have had and the year you had them:

- □ Anemia
- □ Bronchitis
- □ Chicken Pox
- □ Chronic Fatigue Syndrome
- □ Colitis
- □ Diverticulitis
- □ Eczema
- □ Emphysema
- □ Epstein Barr Virus
- □ Eye Disease
- □ Gall Stones
- □ Hemorrhoids
- □ Hepatitis
- □ Hernia
- □ Jaundice
- □ Liver Disease
- □ Lyme Disease
- □ Malaria
- □ Measles
- □ Migraines
- □ Mononucleosis
- □ Mumps
- □ Neuralgia
- □ Pancreatitis
- □ Parasites
- □ Polio
- □ Rheumatic Fever
- □ Tropical Infectious Disease
- □ Typhoid Fever
- □ Yeast Infection

Sexually Transmitted Disease

- □ Herpes
- □ Gonorrhea
- □ Syphilis
- □ HIV
- □ Genital Warts (HPV)
- □ Other _____

Vaccines & Immunizations (Please note the year/date if known):

- □ Chicken Pox
- □ Cholera
- □ Flu
- □ Hepatitis (A / B)
- □ Meningitis
- □ HPV
- □ Malaria Pills
- □ Pneumonia
- □ Polio
- □ Rotavirus
- □ Shingles
- □ Smallpox
- □ Typhoid
- □ Yellow Fever
- □ Tdap (Tetanus, Diphtheria, Pertussis)
- □ MMR (Measles, Mumps, Rubella)
- □ Other: _____

List any significant hospitalizations, or surgeries:

_____

_____

Current Medications - *include dosages, reason for taking, and all side effects*:
(**please list all prescription, non-prescription, herbal and dietary supplements – attach a separate sheet if necessary**)

_____

_____

_____

_____

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

_____

_____

_____

Indicate medications you have ever taken, including dates:

☐ Allergy Shots	☐ Anti-Depressants	☐ Chemotherapy	☐ Pain Medications
☐ Antacids	☐ Antihistamines	☐ Estrogen/Progesterone	☐ Radiation Therapy
☐ Anti-Anxiety Meds	☐ Birth Control Pill	☐ Immunosuppressive Drugs	☐ Thyroid Medication

☐ Other: _____

TOXIC EXPOSURES:

□ Asbestos	□ Coal	□ Lead	□ Tobacco
□ Chemical Fumes	□ Fertilizers	□ Mercury (including fillings)	□ Uranium
□ Chemotherapy	□ Herbicides	□ Other _____	

Smoking? Yes ___ No ___ How much/How long: _____ Do you want to quit? _____

Drink Alcohol? Yes _____ No _____ How much per week: _____ Type: _____

Recreational Drugs? Yes _____ No ____ How often: _____Type: _____

Drink Coffee? Yes ____ No ____ How much per day: _____

Please list what activities you do for exercise and how often: _____

_____

	Exercise	TV	Computer	Yoga	Meditation	Outside	Inside

Hours Spent Daily							

TYPICAL DIET:

Cravings (sweet, salty, sour, bitter, spicy, other) _____

Thirst: ☐ Normal ☐ Rare ☐ Excessive Drink Preference: ☐ Hot ☐ Cold ☐ Iced ☐ Room Temp

How many ounces of water do you drink per day: _____

List any drug allergies and food sensitivities or allergies. Please include reaction when consumed.

_____

_____

_____

_____

How often do you:

Cook for yourself _____ Eat Out _____ Use artificial sweeteners _____

Carbonated Beverages _____ Diet Beverages _____

Are you on a special diet? (if yes, why and please describe): _____

_____

_____

_____

_____

CLIMATIC FACTORS/TIME: Please indicate "B" for best and "W" for worst.

What time of day do you feel your best? __Upon Waking __Daytime __Late Afternoon __Evening __Night

What season do you feel your best/worst? ___Spring ___ Summer ___ Fall ___ Winter

Where do you feel best/worst? ___ At Home ___ At Work ___ Indoors ___ Outdoors (where) _____

What weather makes you feel your best/worst?

___ Cool ___ Cold ___ Damp ___ Dry ___ Fog ___ Hot ___ Rain ___ Snow ___ Warm

Please check any symptoms that apply to you now or were significant health concerns in **the past six months**.
Please comment about the frequency, time of last occurrence, duration, etc. when appropriate.

HEAD & NECK
□ Dizziness
□ Enlarged Lymph Glands
□ Fainting
□ Hair Loss
□ Headaches Type/Location _____

EYES
□ Blurred Vision
□ Contact Lenses
□ Dark Circles
□ Double Vision
□ Dry Eyes
□ Excessive Tearing
□ Eye Inflammation/Redness
□ Eye Surgery
□ Light Sensitivity
□ Pain/Swelling
□ Spots/Floaters

EARS
□ Congestion/Wax Build Up
□ Deafness/Decreased Hearing
□ Discharge
□ Infection
□ Pain
□ Ringing/Tinnitus

NOSE
□ Allergies/Hay Fever
□ Bleeding
□ Congestion
□ Infection
□ Loss of Sense of Smell
□ Pain
□ Post Nasal Drip
□ Runny Nose

MOUTH
□ Bleeding Gums
□ Cavities
□ Change in Sense of Taste
□ Dentures
□ Difficulty Swallowing
□ Dry Mouth/Lips
□ Gum Disease/Loss
□ Oral Herpes (cold sores)
□ TMJ/Jaw Pain
□ Ulcers/Sores in Mouth

MEN ONLY
□ Burning or Discharge from Penis
□ Difficulty with Erection
□ Leakage of Semen
□ Low Sperm Count
□ Pain in Genital Region (hot/cold)
□ Premature Ejaculation
□ Prostate Infections
□ Prostate Surgery/Biopsy
□ Prostate Swelling/Enlargement
□ Swelling or Lumps in Testicles
Method of Birth Control _____
Date of Last Prostate Exam _____
PSA Blood Test Results_____

RESPIRATORY
□ Bronchitis
□ Chronic Cough (dry/productive/color)
□ Coughing Blood
□ Chest Pain (with breathing)
□ Loss of Voice
□ Sensation of something stuck in throat
□ Shortness of Breath
□ Sore Throat
□ Tonsillitis
□ Wheezing/Asthma

CARDIOVASCULAR
□ Ankle Swelling
□ Atrial Fibrillations
□ Bruise or Bleed Easily
□ Chest Pain/Angina
□ Cold Hands/Feet
□ Heart Attack
□ Heart Murmur
□ High Cholesterol
□ Irregular Heart Beat
□ Leg Cramps at Night
□ Mitral Valve Prolapse
□ Palpitations (feel your heart beating)
□ Stroke
□ Tightness in Chest
□ Varicose Veins

GASTROINTESTINAL
□ Appetite Changes (increase/decrease)
□ Belching
□ Black/Tarry Stools
□ Bloating/Gas (Upper or Lower)
□ Constipation
□ Diarrhea
□ Dry/Hard Stools
□ Gall Bladder Problems
□ Hernia
□ Heartburn/Acid Reflux
□ Hemorrhoids
□ Hypoglycemia (low blood sugar)
□ Inflammatory Bowel Disease
□ Mucous in Stool
□ Nausea/Vomiting
□ Stomach Pain
□ Stools Painful to Pass
□ Ulcers
□ Undigested Food in Stool
□ Use of Laxatives
□ Watery Stools
How often do you have a bowel movement?
_____

URINARY
□ Blood in Urine
□ Change in Quantity of Urine
□ Difficulty in Urination
□ Dribbling after Urination
□ Frequent Bladder Infections
  □ with Intercourse
  □ with Stress
□ Frequent Urination
□ Incontinence
□ Kidney Stones
□ Loss of Force of Urination
□ Nighttime Urination
□ Pain/Burning with Urination
□ Pus in Urine
□ Sand/Gravel in Urine
□ Strong Smell to Urine
□ Urination with cough/sneeze
Color of Urine:
□ Clear □ Straw □ Yellow □ Cloudy

REPRODUCTIVE
□ Decreased Sexual Desire
□ Increased Sexual Desire
□ Pain with Sex
□ Infertility

WOMEN ONLY
□ Breast Lumps/Cysts
□ Breast Tenderness
□ Discharge from Nipples
□ Endometriosis
□ Infertility
□ Ovarian Cysts
□ Pelvic Infection
□ Uterine Fibroids
□ Vaginal Discharge
□ Vaginal Dryness

□ Vaginal Infections
□ Vaginal Itching
□ Vaginal Pain

□ Vaginal Sores

Regular Self-Breast Exam? _____
Date of last mammogram _____
Date of last PAP test/Pelvic Exam _____
(Note irregular results)

MENSTRUATION & PREGNANCY

Age of First Period _____
How many days between periods _____
How many days of flow _____
□ Clots with Flow
□ Cramps/Pain (Before/During/After)
Feel Better Before/After Period
□ Heavy Blood Flow
□ Irregular Periods
□ Light Blood Flow
□ No Menstrual Period
□ Premenstrual Bloating
□ Spotting Between Periods
Premenstrual Syndrome Symptoms?
Describe: _____
_____
_____
Are You or Might You Be Pregnant? ____
Number of Pregnancies _____
Number of Abortions _____
Number of Live Births _____
Number of Miscarriages _____
Number of Caesarian Sections _____
Complications with pregnancy, labor or delivery _____
_____
_____
Fertility Treatments? Describe _____
_____
_____
Method of Birth Control:
Current _____
Past _____

PERIMENOPAUSE/MENOPAUSE

Age when Cycle began to change? _____
Age when Menses Stopped _____
Hormone Replacement Therapy? _____
□ Drugs _____
□ Herbs _____
□ Hot Flashes
□ Night Sweats
□ Change in Mood
□ Change in Sex Drive
□ Change in Sleep
Other
_____

ENDOCRINE/IMMUNOLOGIC

□ Abnormal Weight Gain
□ Depression
□ Diabetes
□ Dry Skin
□ Fatigue
□ Frequent Low Grade Fever
□ Hair or Nail Changes
□ Intolerance to
□ Cold □ Heat □ Wind
□ Loss of Feeling of Wellbeing
□ Night Sweats
□ Perspiration
□ Diminished □ Excessive
□ Swollen Lymph Glands
□ Unexplained Fever or Chills

NEUROLOGIC

□ Changes in Handwriting
□ Dizziness
□ Drowsiness
□ Fainting
□ Loss of Coordination
□ Loss of Sensation
□ Memory Changes
□ Muscular Weakness
□ Nerve Pain _____
□ Nervousness
□ Numbness _____
□ Paralysis _____
□ Seizures – Type _____
□ Tremors

SKIN

□ Abnormal Sweating
□ Acne (what causes?/Where?)
_____
□ Changing Moles or Lumps
□ Dryness
□ Herpes
□ Itching
□ Pigment Changes
□ Psoriasis
□ Rash
□ Warts

MUSCULOSKELETAL

□ Arthritis _____
□ Disc Injury _____
□ Joint Swelling _____
□ Joint Stiffness _____
□ Muscle Spasm _____
□ Sciatica

Location of Pain _____

□ Scoliosis
□ Osteoporosis – How Long _____
Pain:
□ Burning □ Achy □ Intermittent
□ Sharp/Stabbing □ Constant
□ Changes Location
Better With:
□ Rest □ Movement □ Ice □ Heat
□ Touch/Massage
Worse With:
□ Rest □ Movement □ Ice □ Heat
□ Touch/Massage
Has your pain shifted from one side of your body to the other? _____

SLEEP

□ Difficulty Falling Asleep
□ Difficulty Staying Asleep
□ Disturbing Dreams/Nightmares
□ Insomnia
□ Sleep Apnea
□ Snoring
□ Wake to Urinate
Position You Sleep in _____
Type of Pillow _____

Informed Consent

Justin Ehrlich, L.Ac. is a Licensed Acupuncturist. He does not claim to diagnose, treat, cure or prevent any medical conditions or pathologies, nor prescribe medicines. The services of a Licensed Acupuncturist do not replace those of a medical doctor. For any medical condition, you are advised to seek care from an appropriate licensed medical practitioner. Whether you choose to engage a medical doctor or not is your right and Justin Ehrlich, L.Ac. assumes no responsibility for your decision in this matter.

I, the undersigned, assume any and all responsibility for decisions regarding my health, recognizing that (a) no claims are made that acupuncture, herbal medicines, nutritional supplements, dietary or exercise therapies 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 or effectiveness of any specific acupuncture, herbal medicine, nutritional supplement, dietary or exercise therapy recommendations, (d) I am free to act upon or disregard the recommendations of Justin Ehrlich, L.Ac. as I so choose.

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 the patient named above, for whom I am legally responsible).

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, far-infrared heat, cupping, gua sha, electrical stimulation, tui na (therapeutic massage), internal and topical herbal medicines, nutritional supplements, exercise therapies and nutritional counseling.

I have been informed that acupuncture is a 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 and fainting. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture. 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 far-infrared heat. I understand that while this document describes the major risks of treatment, other side effects 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 Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify the acupuncturist if I am or become pregnant. I will also immediately notify the acupuncturist if there are any unpleasant effects associated with the consumption of the herbs.

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 the 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 conditions for which I seek treatment with no constraints.

Patient Name (Print) _____

Patient Signature _____ **Date** _____
(or Patient Representative—indicate relationship if signing for patient)

Office Signature _____ **Date** _____
Justin Ehrlich, L.Ac.

This notice describes how health information about our patients may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our Commitment to Your Privacy
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

Use And Disclosure Of Your Health Information In Certain Special Circumstances
The following circumstances may require us to use or disclose your health information:
1. To public health authorities/health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers' Compensation and similar programs.
9. Data that is collected by Justin Ehrlich, L.Ac., which does not include the identity of the patient, may be utilized for research purposes.

Your Rights Regarding Your Health Information
1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Justin Ehrlich, L.Ac. 4443 30th Street, Suite 210, San Diego, CA 92116 at (619) 535-1876 who will have up to 30 days to comply.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Justin Ehrlich, L.Ac. 4443 30th Street, Suite 210, San Diego, CA 92116 at (619) 535-1876 who will have 60 days to respond. You must provide us with a legitimate reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices. At any time, you may obtain a copy of this notice by contacting our front desk receptionist.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint, contact Justin Ehrlich, L.Ac. 4443 30th Street, Suite 210, San Diego, CA 92116 at (619) 535-1876. All complaints must be submitted in writing; you will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact your physician. I hereby acknowledge that I have been presented with a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

Print Name: _____

General Authorization to Release Health Information
I hereby authorize the release of my personal health information to any health provider approved by my treating physician. I understand that I may cancel this authorization at any time by notifying my treating physician in writing.

Signature: _____ Date: _____

Print Name: _____