The Parani Clinic
Acupuncture Herbs Nutrition

Affordable Wellness for Everyday People
COTATI COMMUNITY ACUPUNCTURE

Patient Name **Date of Birth**

Reason for Visit

		How Long?	Severity? (1-10)
#1			
#2			
#3			

Insurance Information

Company ID number

Group Number Plan Name

Is patient same as insured? Relation to Insured:

Are these complaints associated with...

An Auto Accident?

Company Claim Number

Accident Date & Location

Do you have a secondary?

Company

ID:

Personal Information

Male ☐ Female ☐ Phone Email

Address City, Zip

Emergency Contact Phone

Privacy Information: I agree to the privacy practices of this office. Initial:________

Medical Information (check all that apply, current or previous)

☐ Allergies	☐ Insomnia	☐ Cancer	☐ Menstrual Issues
☐ Skin Conditions	☐ Pregnant	☐ Nausea/Vomiting	☐ PMS
☐ Asthma	☐ Surgeries	☐ Scoliosis	☐ Headaches
☐ Fatigue	☐ Fractures	☐ Blurring of Vision	☐ Anemia
☐ Diarrhea	☐ High Cholesterol	☐ Kidney Disease	☐ Chronic Pain
☐ Constipation	☐ Diabetes	☐ Heart Disease	☐ Arthritis
☐ Heartburn	☐ Hypertension	☐ Menopause	☐ Weight Concerns

Patient Name

Medications	Name	Dosage	Reason
#1			
#2			
#3			
#4			
#5			

Are there more?

Supplements, Herbs, Vitamins, etc. (please list)

Dietary Information (please try to list everything you ate or drank yesterday)

Breakfast

Lunch

Dinner

Other

Sleep Information

About how many hours of sleep do you get per night?

Cautions and Concerns

Is there any chance you are pregnant, or will be soon?

Do you have any electronic implants?

Do you have AIDS, Hepatitis, Diabetes, Lymphedema, or Cellulitis?

Anything else we should know?

Patient Name

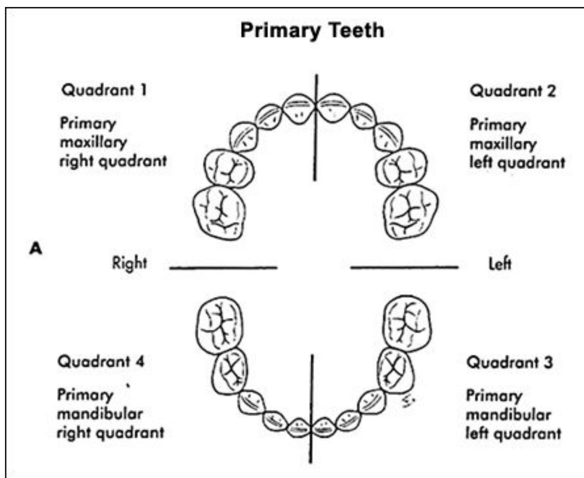
Childhood History

Was your birth dangerous or complicated? Please explain.

Did you have frequent ear infections as a child?

Many doses of antibiotics as a child?

Dental History (To the best of your ability indicate any root canals, crowns or abscesses.



What is your ethnic lineage? (This helps us understand your health and dietary risks)

Chemical and Occupational Exposures

Do you have any history of prolonged or significant exposure to chemicals?

Do you have reactions if you are exposed to new carpet, new cars, or perfume?

Are you sensitive to coffee?

Patient Name

Medical History (Please list all major surgeries (including tonsils, gall bladder or appendix) illnesses, or important medical events and the dates.)

Family Medical History (indicate any relations who suffered from cancer, heart disease, strokes, auto-immune conditions or other significant illnesses.)

Current and Recent Medical Care

Who is your current primary care provider?

Practice Location?

Are you seeing any specialists? (please list)

Release Disclosure

In the interest of providing for the best possible coordination of care our office sends a letter to patients' primary care providers, informing them of our findings, treatment modalities and goals of treatment. This also opens lines of communication ensuring that all concerns are addressed. Do you give us permission to send your primary care physician a report of our findings and treatment intentions?

Signature: Date:

Any other providers you would like us to contact?