

Karen A. Brown L.Ac.
 881 Fremont Avenue, Suite A5
 Los Altos, CA 94024
 408 202-9375

To help us meet all of your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistant, I would be happy to help you.

Patient Confidential Information

Name		Date	
Soc sec number	Date of birth	Home phone Email Cell	
Address:			
Check appropriate: 0 single 0 married 0 separated 0 divorced 0 widowed 0 minor			
Students only: Name of college		0 full time 0 part time	
Patients employer		Work phone	
Work address			
Whom may we thank for referring you?			
Person to contact for emergency		Phone	

Responsible Party

Person responsible for payments		Relationship	
Address			
Drivers license number	Date of birth	Social security number	
Employer	Work number	Cell number	
Payment by Insurance	Cash	Check	

Insurance Information (only if you are using insurance)

Name of insured		Relationship	
Date of birth	Social security or ID #	Date employed	
Employer		Work phone	
Employer address			
Insurance company		Group #	Policy #
Insurance address			
Deductible?	Have you met deductible?	Max visit per year	
Insurance phone number			
Do you have additional insurance?			

Medical History

Primary care physician	Phone	Date of last exam
Are you on any medications? 0 yes 0 no	Have you ever been hospitalized? 0 yes 0 no	
Please list medications:	Please list dates and diagnosis:	
Are you under treatment now? 0 yes 0 no	Have you ever taken Phen-Fen/Redux 0 yes 0 no	
Please explain:	Women: Are you pregnant? 0 yes 0 no	
Do you use tobacco? 0 yes 0 no Do you used recreational drugs? 0 yes 0 no	Are you nursing? 0 yes 0 no	
Are you wearing contacts? 0 yes 0 no	Are you taking oral contraceptives? 0 yes 0 no	
Do you have any of the following allergies?		
Environmental	yes	no
Medications	yes	no
Sulfa drugs	yes	no
Foods	yes	no
Aspirin	yes	no
Metals	yes	no
Latex rubber	yes	no
Others:		
Please check any of the following that you currently have. Put an X if you have had in the past.		
High blood pressure	Heart disease	Chest pains
Heart attack	Cardiac pacemaker	Easily winded
Rheumatic fever	Heart murmur	Stroke
Swollen ankles	Angina	Hay fever/allergies
Fainting/seizures	Frequently tired	Tuberculosis
Asthma	Anemia	Radiation therapy
Low blood pressure	Emphysema	Glaucoma
Leukemia	Cancer	Recent weight loss
Diabetes	Arthritis	Liver disease
Kidney disease	Joint replacement/implant	Heart trouble
AIDS/HIV	Hepatitis/jaundice	Respiratory problems
Thyroid problems	Sexually transmitted disease	Mitral valve prolapse
Stomach problems	Dizziness	Other

Family Medical History (Diseases of your parents or siblings) Indicate who had the disease.

Stroke	Mental disorder
Asthma	High blood pressure
Allergies	Diabetes
Cancer	Multiple sclerosis
Other	
Reason for visit	
Date it began	Who has treated you for this?
Have you had acupuncture in the past? 0 yes 0 no	

I hereby request and consent to treatments with Chinese medicine including acupuncture, herbs, an other modalities from the above acupuncturist. I have read and signed the informed consent and arbitration agreements. I agree to be responsible for all charges whether or not paid by insurance. I authorize the release of information necessary for evaluation and administration of claims for insurance benefits.

Date	Signature	Print name
------	-----------	------------