



# Pacific Healing Arts

Lee Holden L.A.c

Please fill this form out as accurately as possible.  
All information will be kept confidential in your file.

Name \_\_\_\_\_ Email: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Marital Status: S M D W Occupation \_\_\_\_\_ Birthdate \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Home Phone: Best # To Reach:	In Case of Emergency	Name Phone
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Are you being treated elsewhere? Y N If yes, where? \_\_\_\_\_

Are you currently using prescriptions or herbal medicines? Y N if yes, please list below \_\_\_\_\_

**Medical History:** What type of exercise are you currently doing, and how often?

Check all that apply

- |  |  |
|--|--|
| Arthritis <input type="checkbox"/>           | Menstrual Irregularity <input type="checkbox"/>  |
| Allergies <input type="checkbox"/>           | Thyroid <input type="checkbox"/>                 |
| _____  | Vaginal Infections <input type="checkbox"/>      |
| Anemia <input type="checkbox"/>              | Psychological Disorders <input type="checkbox"/> |
| Asthma <input type="checkbox"/>              | Stress High Normal Low _____                     |
| Bleeding Tendency <input type="checkbox"/>   | Surgery <input type="checkbox"/>                 |
| Blood Pressure High Low _____                | _____  |
| Bronchitis <input type="checkbox"/>          |  |
| Cancer _____                                 |  |
| Chronic Fatigue <input type="checkbox"/>     |  |
| Diabetes <input type="checkbox"/>            |  |
| Digestive Disorders <input type="checkbox"/> |  |
| Emphysema <input type="checkbox"/>           |  |
| Epilepsy <input type="checkbox"/>            |  |
| Headaches <input type="checkbox"/>           |  |
| Heart Disease <input type="checkbox"/>       |  |
| HIV + <input type="checkbox"/>               |  |
| Hypoglycemia <input type="checkbox"/>        |  |
| Injuries <input type="checkbox"/>            |  |
| _____  |  |
| Insomnia <input type="checkbox"/>            |  |

## Major Complaint:

My signature authorizes Lee Holden L.A.c to treat me (or the patient for whom I am legally responsible) with acupuncture and Chinese herbs within the licensure 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 judgement during the course of the procedure, which the acupuncturist feels based upon the facts then known, is in my best interest.

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.

Office Policy:

Sign & Date: \_\_\_\_\_

All fees for medical services are due at the time of visit unless arrangements have been made with Pacific Healing Arts. If you need to cancel an appointment, please give us a minimum of 24 hrs notice. There may be a cancellation fee assessed