David Lee Acupuncture
166 N. Moorpark Road #201
Thousand Oaks, CA 91360 P:805.497.6200

Date_____

PATIENT CONFIDENTIAL INFORMATION (PLEASE PRINT)

Patient_____ Social Security #_____
First Name Last Name Initial

Home Phone(_____)_____ Cell Phone(_____)_____ E-mail_____

Street Address_____ City_____ State____ Zip_____

Sex: ☐M ☐ F Age_____ Birthdate_____ ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Occupation_____ Business Phone(_____)_____

Who may we thank for referring you? _____

What is your illness/injury? _____

Have you seen any other doctor about this condition? ☐Yes ☐No If yes, when? _____

Who is your physician? Name_____ Phone (_____)_____

Is your condition related to employment (current or previous)? ☐Yes ☐No
Employer's Name_____
Is your condition related to auto accident? ☐Yes ☐No If yes, when? _____
Other accident? ☐Yes ☐No Please describe: _____

FOR FEMALES: Are you pregnant? ☐Yes ☐No If yes, for how long? _____
FOR MINORS: parent's name and date of birth _____
_____

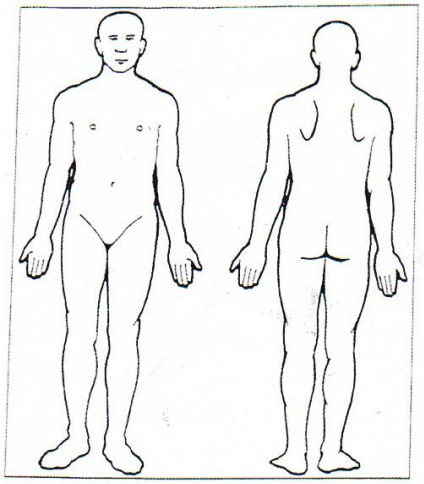
In case of emergency, call:
Phone(_____)_____
Name_____
Relationship to patient_____

FINANCIAL ARRANGEMENTS
How do you plan to handle your account?
☐Cash ☐Check ☐Visa/Master ☐AmEx

INSURANCE INFORMATION
Do you have personal, group health
or accident insurance? ☐Yes ☐No

If yes, please have the office make a copy
of your insurance card.

Please mark the locations of pain or discomfort.



PATIENT CONFIDENTIAL INFORMATION **Patient name**_____

Please complete the following as accurately as possible.

❒ epstein barr virus (EBV) ❒ cold sores ❒ genital herpes ❒ heart disease ❒ rheumatic fever ❒ high blood pressure ❒ stroke ❒ kidney disease ❒ urinary bladder problems or infections ❒ diabetes mellitus ❒ cancer ❒ pneumonia ❒ emphysema ❒ tuberculosis ❒ asthma ❒ peptic ulcer ❒ anemia or other blood disorder ❒ bleeding disorder ❒ fibromyalgia ❒ osteoarthritis ❒ rheumatoid arthritis ❒ mental disorder ❒ gout ❒ hepatitis ❒ liver cirrhosis ❒ gall stones ❒ jaundice ❒ hernia	❒ thyroid disorder ❒ disorder of genitals ❒ gynecological disorder ❒ congenital abnormalities ❒ skin diseases ❒ elevated cholesterol ❒ cardiac pacemaker ❒ surgical implants ❒ change in bowel or bladder habits ❒ sores that will not heal ❒ unusual bleeding or discharge ❒ indigestion ❒ sjögren's disease ❒ crohn's disease ❒ irritable bowel disease ❒ lupus erythmatosis ❒ difficulty swallowing ❒ obvious change in a wart or mole ❒ alzheimer's ❒ parkinson's ❒ epilepsy or convulsions ❒ history of smoking #_____ day ❒ history of smokeless tobacco use ❒ history of drinking alcohol ❒ history of recreational drug use ❒ history of sexually transmitted disease ❒ HIV

PATIENT CONFIDENTIAL INFORMATION **Patient name_____**

Please complete the following as you feel are significant to you.

❒muscle pain ❒shoulder pain ❒elbow pain
❒knee pain ❒low back pain ❒neck pain
❒other joint or muscular pain: _____
❒migraine headache ❒tension headache ❒cluster headache

❒cold/flu/bronchitis/pneumonia ❒hay fever/allergies ❒asthma
❒nose bleeds frequently ❒wheezing ❒bad breath
❒tongue sores ❒lack of thirst/forget to drink ❒easy thirst/dry mouth/dry throat

---

❒poor or no appetite ❒high hunger ❒nausea
❒bloating/indigestion/acid reflux ❒abdominal pain/cramp/ulcer
❒hemorrhoids ❒hard dry stools ❒chronic loose stools/diarrhea
❒bowel movement every ____ days

❒vertigo, dizziness ❒ringing in ears ❒palpitations/irregular heartbeat
❒color blind ❒dry eyes ❒hair loss
❒eczema/acne/skin eruptions ❒skin tags on neck ❒fatty nodules under skin
❒brittle nails ❒edema/ water retention
❒difficult gaining weight ❒difficult losing weight

❒I get chills easily ❒cold hands and feet ❒wear socks to sleep often
❒cannot take cold shower ❒my body is constantly hot
·My body accepts more: ❒ the Winter season ❒ the Summer season

---

❒insomnia ❒sleeping too much ❒night sweats
❒anxiety/depression/worry ❒ADD/ADHD (attention deficit disorder/attention deficit hyperactive disorder)

❒incontinence of urine ❒frequent urination ❒cloudy / bubbling urine
❒painful burning urination ❒bladder-kidney stones ❒ urinate_____ x night

Please complete the following as you feel are significant to you.

·How often do you urinate during the day?
❒every hour ❒every 2 hours ❒every 3 hours ❒every 4 hours

·When passing the bowel, does it most of the time feel complete ❒ or often feel unrelieved? ❒

·When passing the bowel, do you sit for a pro-longed period ❒ or is it excreted in a few seconds? ❒

·How many hours do you need to sleep through the night? _____ hours

·Do you enjoy meats❒ or do you find them to be heavy and hardly digestible? ❒

·Do you enjoy fried foods❒ or do you find them to be heavy and hardly digestible? ❒

PATIENT CONFIDENTIAL INFORMATION **Patient name**_____

·Have you been on the Atkins Diet and did well❒ or got sick from it? ❒

·Do you get seasick or motion sickness easily? ❒yes ❒no

·Do you see yourself accomplishing tasks at the last moment❒ or by step-by-step increments? ❒

·Are you highly sensitive to initially perceived criticisms❒ or do you let them pass easily? ❒

· When I act or move, I sweat ❒a lot ❒little ❒almost never.

· I usually sweat on my: ❒head ❒face ❒neck ❒back ❒upper body
❒arm pit ❒lower body ❒whole body ❒palm and sole

· You have special fear of or discomfort with ❒height ❒closed places ❒open places ❒insects/reptiles

· Childhood/infantile illnesses ❒wetting bed other _____

Check any of the following that gives you negative reaction:
❒caffeine ❒milk/dairy ❒wheat/gluten ❒shellfish ❒dander/dust/pollen ❒egg
❒melon ❒mango ❒perfumes ❒penicillin ❒nickel in jewelry
❒other_____

Are you taking herbs?_____

MEN
❒potency issue ❒prostatitis ❒fertility difficulties

WOMEN
Age when periods began_____ Last pap smear date_____
Duration of flow /days _____ Is your cycle regular? ❒yes ❒no
Date of the last period _____ Do you believe you are pregnant? ❒yes ❒ no

Difficulties during period: ❒excessive flow ❒less flow ❒cramps ❒clots ❒breast distension
❒emotional changes

❒fertility difficulties ❒habitual miscarriage ❒ breast cysts ❒low libido ❒menopausal symptoms
❒ vaginal yeast (candida) infections
Menstrual cramps: ❒every or almost every period ❒infrequent
Birth control history, method, & duration of use_____

____pregnancies ____births ____abortions ____miscarriages ____c-sections

PATIENT CONFIDENTIAL INFORMATION **Patient name_____**

What is your major history of illnesses?

_____

_____

Surgeries & dates _____

_____

What is your health goal through the treatment at this clinic?
❒pain management ❒treatment of the illness ❒preventative lifestyle

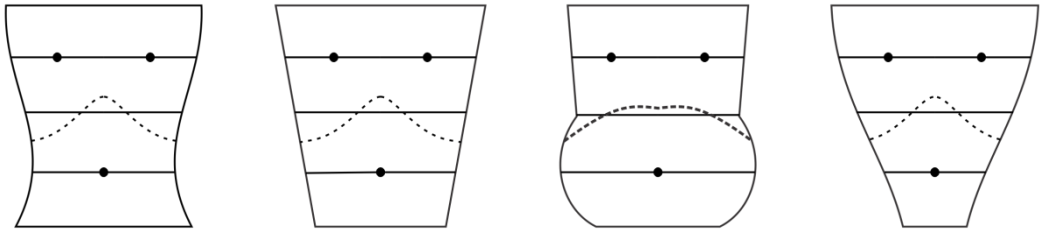
From the above, which conditions bother you the most?

_____

Patient Torso Measurement Agreement

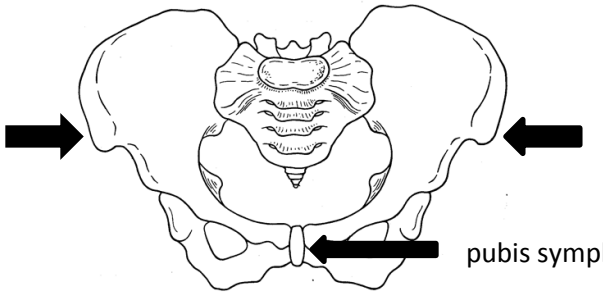
Dr. David Lee's acupuncture style is based on Four Constitutional Medicine, where knowing your torso shape facilitates identifying your body type and therefore leads to proper treatment for your ailments. He determines your body type diagnosis by measuring five lines as illustrated below with a caliper (a measuring ruler). For females, the second line across the chest is not measured for protection of privacy.

Exaggerated example of torso shapes:



Lesser Yin | Lesser Yang | Greater Yin | Greater Yang

Three points of palpation:



The sides and front of the pelvic bone is also palpated. Below the pubis symphysis is not palpated.

I approve of Dr. David Lee measuring my torso and palpating my pelvic bone for the purpose of establishing an Asian medical diagnosis for the treatment of my illnesses.

_____ _____ _____

Patient Name | Patient Signature | Date

FINANCIAL POLICY & PATIENT RESPONSIBILITY

We request payment at the time service is provided. We are able to accept the payment in forms of cash, check, American Express, Visa, Discover, and MasterCard.

Charge Rates
Acupuncture for each visit is $70. Initial consultation fee is $30.
Herbs are $70 per bottle for a one week supply.
Acupuncture and herbs package fee is $110.
Dietary consultation fee is $40.
You will be given options to best treat your complaints.

Philosophy
We make the highest effort to serve the patients as quickly and economically as possible. Usual visits are twice a week for the first few weeks and once a week thereafter. Refer to the brochures that pertain to you and ask Dr. David Lee about how long and how often your treatments should be to achieve maximum recovery.

Insurance
If you are requesting to pay for your care through your insurance company, make sure you are clear with your insurance carrier about your responsibilities, such as deductible and co-pay. Due to the varying calculations involved, please *do not assume the final payment* until you receive the explanation of benefit from your insurance carrier. Please note that you, the patient, have the final financial responsibility for your care. If your acupuncture insurance benefits seem to be vague, then *you may be requested to make full payment until the explanation of benefits is received*. Chinese herbs and dietary consultations are not covered by any insurance plan. I hereby authorize David Lee Acupuncture to release all information necessary to process any insurance or collection claims.

Cancellation Policy
David Lee Acupuncture's cancellation policy requires patients to give a 24-hour notice of cancellation prior to their appointment. As time and space is limited someone else may be able to take your spot if a 24-hour notice is given. If you are not sure you will make your scheduled appointment, please do not schedule it. We ask that you please value our time and understand the reason for our cancellation policy.

The cancellation fee for missed appointments or appointments cancelled without a 24-hour notice is $40. Patients will not be able to see the doctor for another appointment until the cancellation fee is paid. Exceptions may be made for emergencies on a case-by-case basis. By signing below you are acknowledging our cancellation policy and agreeing to pay $40 for missed appointments or appointments cancelled without a 24-hour notice. Thank you for your cooperation.

I understand and agree to the fees outlined above and may receive a copy of this Financial Policy & Patient Responsibility form upon request.

Name _____ Signature _____ Date_____
Parent/Guardian if patient is a minor