Jung Sook Kim L.AC
1157 W. Grand Blvd, Corona, CA 92882
951 808-0954

PATIENT INFORMATION

Name:_____ SSN: _____-_____-_____ DOB: _____ AGE: _____

Address:_____ City:_____ State:_____ Zip:_____ Marital: M S W D

Home Phone #:_____ Cell Phone #:_____ Race:_____ Sex: M F

Occupation:_____ Employer:_____ Employer Phone #:_____

Emergency Contact:_____ Phone:_____ Relationship:_____

Email:_____ How did you hear about us?_____

Have you had acupuncture treatment before?_____ When was your last treatment?_____

HEALTH HISTORY

Please check all of the following that apply to you and list any medication(s) you are taking:

☐ Alcohol/Drug Dependence
☐ Abnormal Menstruation
☐ Allergies
☐ Angina
☐ Rheumatoid Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disorder
☐ Breast Lumps
☐ Cancer/Tumor
☐ Convulsions/Seizures
☐ Diabetes
☐ Diarrhea/Constipation
☐ Excessive Thirst
☐ Fainting of Dizziness
☐ Fatigue
☐ Fever
☐ Diabetes _____
☐ Other _____

☐ Frequent Urination
☐ Headache
☐ Heart Attack
☐ Heartburn or Indigestion
☐ Hospitalizations/Surgical Procedures
_____
_____
☐ Kidney Disease
☐ Liver Problems
☐ Osteoporosis
☐ Pacemaker
☐ Palpitation/Arrhythmia
☐ Peptic Ulcer
☐ **Pregnant**, # Weeks _____
If pregnant, are you under a medical doctor's Care? ☐ Y ☐ N
☐ Prostate Problems

☐ Weight Gain/Loss
☐ Sinusitis
☐ Stroke
☐ Tobacco Use – Type
☐ Thyroid Disease
☐ Vertigo_
☐ Other_____
☐ Medications:_____
_____

If a family member has had of the following, please mark the appropriate box and explain the relationship:
☐ Cancer _____
☐ Heart Disease _____
☐ Hypertension _____
☐ Lupus _____

PATIENT CONDITION

Please describe your current health problem(s): _____

How and when it began: _____ Is this work related? Y / N

What treatment have you received for the above condition(s)? ☐ Surgery ☐ Medications ☐ Physical Therapy
☐ Injections ☐ Chiropractic ☐ Massage ☐ Other _____
Please describe your progress:
☐ Worse ☐ No Change ☐ 0-25% Better ☐ 26-50% Better ☐ 51-75% Better ☐ 76-100% Better

Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other_____

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

In the past week, how much was your pain interfered with your daily activities?

No Interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

How often are your symptoms present? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Describe your current health condition: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

It interferes with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Other _____

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Laying Down
☐ Other _____

Exercise:	Work Activity:	Habits:	Injury/Surgeries:
☐ None	☐ Sitting	☐ Smoking	☐ Falls:_____
☐ Moderate	☐ Standing	☐ Alcohol	☐ Head Injuries:_____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	☐ Broken Bones:_____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	☐ Surgeries:_____

INSURANCE INFORMATION

Who is responsible for this account?_____ Relationship to Patient:_____

Insurance Co.:_____ ID #:_____ Group #:_____

Name of Secondary Insurance Company, if any:_____ ID #:_____

Subscriber:_____ DOB:_____ Relationship to Patient:_____

ASSIGNMENT OF BENEFITS – FINANCIAL AGREEMENT

Assignment and release: I authorize payments and benefits to be made directly to this provider and I understand I am responsible for charges not covered by this assignment. I also authorize the release of any information requested to process this claim. I agree to pay for any appointments in full that I miss or do not cancel within 24 hours in advance.

Patient Signature:_____ Date:_____