

Patient Parent Guardian

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ (mm/dd/yyyy) Gender: M F

Address: _____

City: _____ State: _____ Zip: _____

Marital Status: Single Married Divorced Widowed Partner

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Height: _____ Weight: _____ lbs

Children (Age & Gender): _____

Primary Physician: _____ Phone: _____ Referred by: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Insurance Name: _____

Primary Insured ID Number: _____

Insurance Group Number: _____

Primary Insured Name: Last Name: _____ First Name: _____ MI: _____

Primary Insured Date of Birth: _____ (mm/dd/yyyy)

Patient's relationship to Primary Insured: Self Spouse Child Guardian

Health conditions related to work or auto accident? Y N If so, Date of Loss: _____ (mm/dd/yyyy)

I. Goals: What would you like to address through treatment?

II. Medications / Supplements

Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

Allergies (to medications, chemicals or foods): _____

III. Lifestyle

1. What is your occupation? _____ How many hours do you work weekly? _____

2. How many servings per day do you use of the following?

Coffee _____ Tea _____ Soft drinks _____ Alcohol _____ Water _____ Cigarettes, cigars, or other tobacco _____

3. Do you have a known history of any exposure to toxic substances? Yes No

4. Please describe your current exercise regimen: Hours per week: _____ Activities: _____

5. How many hours of sleep do you usually get per night? _____

Do you awake feeling rested? Yes No Do you sleep soundly? Yes No

Do you get up at night to urinate? Yes No If so, how often? _____

6. Frequency of bowel movement: _____ per day or _____ per week

What is the color of stool? _____

For Women:

1. Age: First period _____

Menopause: Yes No

a) Average number of days of flow: _____ days The flow is: Normal Heavy Light

c) The color is: Normal Dark Purple Light Brown Brown

d) Time between periods: _____ Days

2. Are you pregnant now? Yes No Unsure

3. Indicate number of occurrences: Live Births _____ Pregnancies _____

4. Dates: Last Pap Smear _____ (dd/mm/yyyy) Last Mammogram _____ (dd/mm/yyyy)

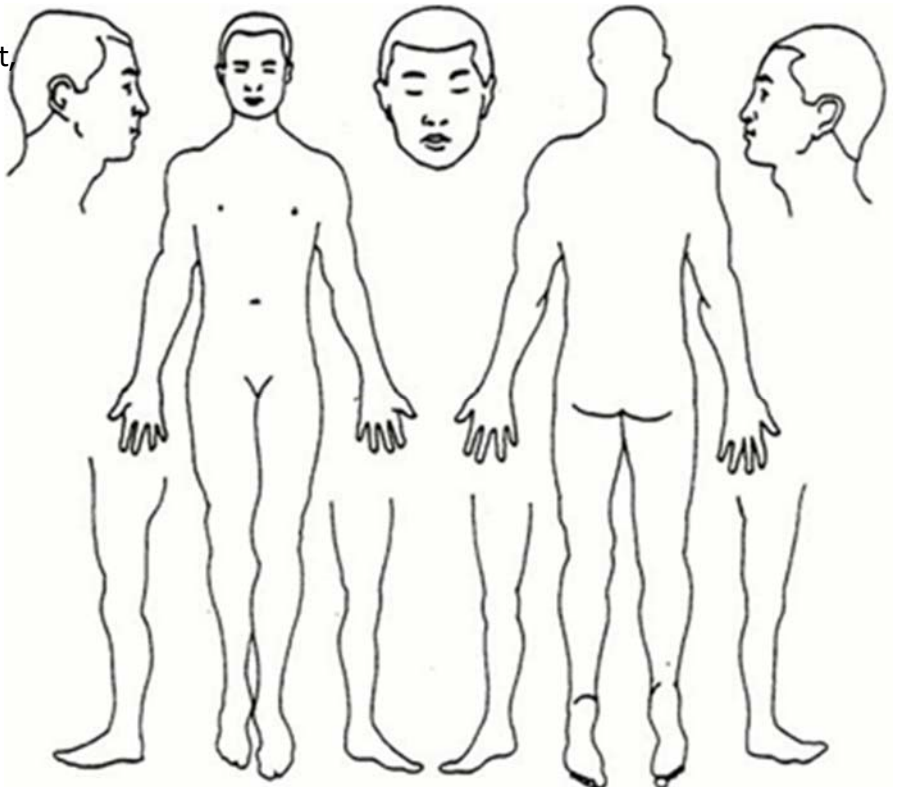
For Men:

Do you have any bothersome urinary, genital, or sexual symptoms? Yes No

If yes, please describe: _____

IV. Pain

If you are experiencing pain/discomfort using the models to the right, please indicate the location of the discomfort by using the below symbols that best describes the feeling.



- A** Aching
- B** Burning
- C** Cramps
- D** Dull
- E** Effusion (Swelling)
- N** Numbness
- S1** Sharpness
- S2** Shooting
- S3** Sprain
- S4** Stiffness
- S5** Strain
- T1** Tingling
- T2** Throbbing
- O** Other

Please describe pains in the order of the severity. **Top priority first, please.** For example, Headache, Neck, Shoulder, Arm, Elbow, Wrist, Hand, Finger, Upper Back, Lower Back, Sciatica, Abdominal, Hip/pelvis, Thigh, Knee, Calf, Foot, Ankle, Toe and etc.

V. HEALTH: Please check all that apply, left for past right for current

Head (Face and Eyes)		Thoracic Spine		Wrist and Hand	
R51	Headache	M54.6	Pain in thoracic spine	M79.641	Pain in right hand
G43.111	Migraine with aura	M20-M25	Pain in unspecified joint (spine, thoracic)	M79.642	Pain in left hand
G43.011	Migraine without aura			M79.644	Pain in right finger(s)
G43.711	Chronic migraine without aura	M47.814	Thoracic spondylosis without myelopathy	M79.645	Pain in left fingers(s)
G43.911	Migraine, unspecified			M70.11	Bursitis right hand
J34.89	Other disease of nasal cavity and sinuses (pain)	S29.012A	Strain of muscle and tendon of back wall of thorax initial encounter	M70.12	Bursitis left hand
H92.09	Otalgia, unspecified ear (ear pain)	Lower Back (lumbosacral)		M25.631	Stiffness of right wrist, not elsewhere classified
R68.84	Jaw pain	M54.5	Low back pain (lumbago)	M25.632	Stiffness of left wrist, not elsewhere classified
Z98.89	Other specified postprocedural states (dental with pain)	M54.41	Lumbago with sciatica, right side		
		M54.42	Lumbago with sciatica, left side	Knee and Thigh	
Neck		M54.31	Sciatica, right side	M25.561	Pain in right knee
M54.2	Cervicalgia (Neck pain)	M54.32	Sciatica, left side	M25.562	Pain in left knee
M25.50	Pain in unspecified joint (spine, cervical)	M25.50	Pain in unspecified joint (spine, lumbar or lumbosacral)	M79.651	Pain in right thigh
R07.0	Pain in throat	M54.89	Other dorsalgia	M79.652	Pain in left thigh
M50.31	Cervical disc degeneration occipito-atlanto-axial region	S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter	M79.661	Pain in right lower leg
M50.32	Cervical degeneration mid-cervical			M79.662	Pain in left lower leg
M50.33	Cervical disc degeneration cervicothoracic region	M70.51		M70.51	Other bursitis of knee, right knee
M47.813	Thoracic spondylosis without myelopathy or radiculopathy cervicothoracic region	Pelvis		M70.52	Other bursitis of knee, left knee
M47.814	Thoracic spondylosis without myelopathy or radiculopathy thoracic region	M25.551	Pain in right hip	M25.461	Effusion (swelling), right knee
		M25.552	Pain in left hip	M25.462	Effusion (swelling), left knee
		M25.651	Stiffness of right hip, not elsewhere classified	M25.661	Stiffness of right knee, not elsewhere classified
		M25.652	Stiffness of left hip, not elsewhere classified	M25.662	Stiffness of left knee, not elsewhere classified
		M25.451	Effusion (swelling), right hip	Ankle and Foot	
		M25.452	Effusion (swelling). Left hip	M25.579	Pain in unspecified ankle and joints of right foot
		S33.8XXS	Sprain of other parts of lumbar spine and pelvis, sequela	M25.672	Pain in unspecified ankle and joints of left foot
Shoulder		Abdomen		M79.671	Pain in right foot
M25.511	Pain in right shoulder	R10.11	Right upper quadrant pain	M79.672	Pain in left foot
M25.512	Pain in left shoulder	R10.12	Left upper quadrant pain	M79.674	Pain in right toe(s)
M75.51	Bursitis of right shoulder	R10.31	Right lower quadrant pain	M79.675	Pain in left toe(s)
M75.52	Bursitis of left shoulder	R10.32	Left lower quadrant pain	M25.471	Effusion (swelling), right ankle
M79.601	Pain in right arm			M25.472	Effusion (swelling), left ankle
M79.602	Pain in left arm	R10.84	Generalized abdominal pain, Abdominal pain, other specified site (multiple sites)	M25.474	Effusion (swelling), right foot
M79.621	Pain in right upper arm			M25.475	Effusion (swelling), left foot
M79.622	Pain in left upper arm	Arm and Elbow		M25.671	Stiffness of right ankle, not elsewhere classified
M25.611	Stiffness of right shoulder, not elsewhere classified	M25.521	Pain in right elbow	M25.672	Stiffness of left ankle, not elsewhere classified
M25.612	Stiffness of left shoulder, not elsewhere classified	M25.522	Pain in left elbow		
		M25.531	Pain in right wrist	Pain - Acute and chronic	
M25.419	Effusion (swelling), unspecified shoulder	M25.532	Pain in left wrist	G89.0	Central pain syndrome
M25.411	Effusion (swelling), right shoulder	M79.631	Pain in right forearm	G89.11	Acute pain due to trauma
M25.412	Effusion (swelling), left shoulder	M79.632	Pain in left forearm	G89.21	Chronic pain due to trauma
S43.50XA	Sprain of unspecified acromioclavicular joint, initial encounter	M70.21	Olecranon bursitis, right elbow	G89.29	Other chronic pain
Muscle		M70.22	Olecranon bursitis, left elbow	Respiratory	
		M25.421	Effusion (swelling), right elbow	R05	Cough
		M25.422	Effusion (swelling), left elbow	R07.0	Pain in throat
M79.1	Myalgia	M25.431	Effusion, right wrist (forearm)	J45.20	Intrinsic asthma, unspecified (mild intermittent asthma, uncomplicated)
M79.7	Fibromyalgia	M25.432	Effusion, left wrist (forearm)		
Nausea		M25.621	Stiffness of right elbow, not elsewhere classified	J45.991	Cough variant asthma
R11.0	Nausea	M25.622	Stiffness of left elbow, not elsewhere classified	J45.998	Other asthma
R11.11	Vomiting without nausea				

VI. Recent Hospitalizations / Surgical History

_____ Date _____

_____ Date _____

_____ Date _____

Other relevant information:

I am receiving acupuncture and related treatments from Byoung Soon Kim L.Ac.

I hereby authorize KOSA Acupuncture to verify information required for processing payment, and to collect payment directly from my insurance.

I understand that if my insurance fails to cover for my treatments or pays me less than the prefixed price (mutually agreed), or pays me directly, I am responsible for making payments. I also authorize the clinic to obtain any medical information on me as needed.

By signing below, I certify that all information I have provided are accurate and to the best of my knowledge.

Client's Name: _____

Client's Signature: _____ Date: _____

For Office's Use Only

Treatments: Acupuncture	Duration:		Hr	Min		
Office visit (New patient):	99201 <input type="checkbox"/>	99202 <input type="checkbox"/>	99203 <input type="checkbox"/>		99204 <input type="checkbox"/>	99205 <input type="checkbox"/>
Acupuncture w/o Electric	1 SET <input type="checkbox"/>	2 SET <input type="checkbox"/>	3 SET <input type="checkbox"/>	4 SET <input type="checkbox"/>		
Electrical Acupuncture	1 SET <input type="checkbox"/>	2 SET <input type="checkbox"/>	3 SET <input type="checkbox"/>	4 SET <input type="checkbox"/>		
Manual Therapy: (Guasha, Tuina)	15 min <input type="checkbox"/>	30 min <input type="checkbox"/>				
Moxa & Cupping:	15 min <input type="checkbox"/>	30 min <input type="checkbox"/>				
Massage:	15 min <input type="checkbox"/>	30 min <input type="checkbox"/>				
Infrared Heat:	15 min <input type="checkbox"/>	30 min <input type="checkbox"/>				
Electrical Stimulation:	15 min <input type="checkbox"/>	30 min <input type="checkbox"/>				
Application of Hot or Cold Packs:	15 min <input type="checkbox"/>	30 min <input type="checkbox"/>				