

531 E A St. Ste 100B, Jenks, OK 74037

Tel: (918) 995-1100

Patient Parent Guardian

Last Name: [redacted] First Name: [redacted] MI: [redacted]

Date of Birth: 1954 (mm/dd/yyyy) Gender: M F

Address: [redacted]

City: [redacted] State: [redacted] Zip: [redacted]

Marital Status: Single Married Divorced Widowed Partner

Home Phone: [redacted] Cell Phone: [redacted] Work Phone: [redacted]

Email: [redacted] Height: 5'4" Weight: 151 lbs.

Children: [redacted]

Primary Physician: [redacted] Phone: [redacted] Referred by: google search

Emergency Contact: [redacted] Phone: [redacted] Relationship: [redacted]

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?

pain management & strengthening fine motor skills

R7L thumbs 3yrs

Rt. CTS 4

Thinning hair

Rt eye floater 8 yrs

Sleep deprivation 3yrs

eye pressure glaucoma

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)

Triamterene
Trian/HCTZ Cap 37.5/25 mg HBP 12yrs Daloxetine 30mg AJA nerve 2yrs

Pantoprazole Sod EC TB 40mg Barrett's esophagus 8yrs

Eszopiclone 3mg tab sleep 4 yrs

Latanoprost OP 501.005 (1 drop eye drops

Zexothin 4mg/Lutten 30mg vitamin

Pregevalin 150mg hands 2yrs

Allergies (to medications, chemicals or foods): None known

III. Lifestyle

1. What is your occupation? Business Administrator How many hours do you work weekly? 40-45

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

Coffee 1 Tea 0-1 Soft drinks 0 Alcohol 0 Water 6-8 Cigarettes, cigars, or other tobacco 0

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: Just began Tai Chi walking

5. How many hours of sleep do you usually get per night? 6
 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? 1

6. Frequency of bowel movement: _____ per day or 5 per week
 What is the color of stool? brown

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 2 Pregnancies 2

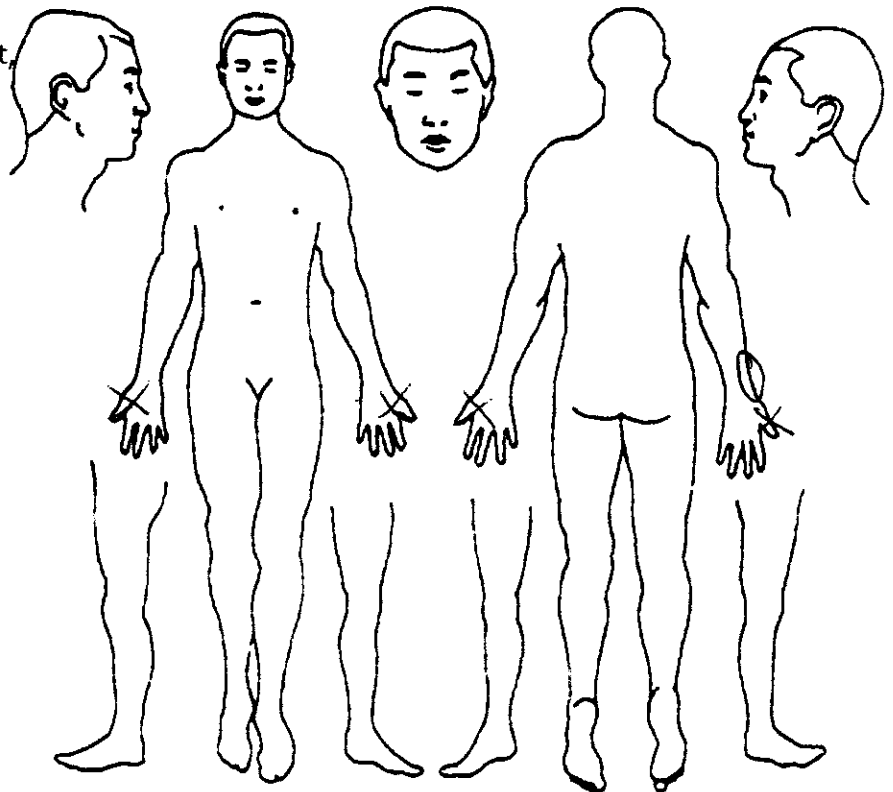
4. Dates: Last Pap Smear ? (dd/mm/yyyy) Last Mammogram 2024 (dd/mm/yyyy)

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.

VI. Recent Hospitalizations / Surgical History

Cataract Removal Date Feb/March 2025
Cervical Disc Surgery Date 2022
Rotator Cuff Surgery Date 2021

Other relevant information:

both knees replaced 2012 & 2013
gastric bypass 2001
hysterectomy 1997

I am receiving acupuncture and related treatments from Byoung Soon Kim MSc.AAOM.

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: [Redacted]

Client's Signature: [Redacted] Date: 12-27-25

For Office's Use Only

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