Irit D. Weir, L.Ac, M.S.
Lic. #AC3166
(707)226-8724
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Acupuncture Clinic of Napa

Confidential Health Inventory

Date:_____

General Information

Email:_____

Name:_____ Age:_____ Birthdate:_____
Last First Middle

Address:_____
Street City State Zip

Mailing Address (if different):_____

Home Phone No._____ Work Phone No._____ SS#_____

Occupation:_____ Employer:_____ Address:_____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ School ☐ Retired ☐ Unemployed ☐ Other:_____

Living Situation: ☐ Alone ☐ Friend(s) ☐ Partner ☐ Spouse ☐ Parents Number of Children:_____

Pets:_____

Status: ☐ Single ☐ Married ☐ Divorce ☐ Widowed

Name of Partner / Spouse / Parent:_____ Occupation:_____
Circle One

Case of Emergency Notify:_____ Phone No._____

How did you hear about the Clinic? _____

Main problem(s) you want to address? _____

_____

How did this condition develop? (What caused it? How did it start?) _____

_____

Have you had this condition or similar condition before? _____

_____

Have you ever received treatment for this condition? ☐ Yes ☐ No

If yes, where? _____

When? _____ By whom? _____

What was the diagnosis? _____

What were the results of treatment? _____

_____

Has this condition been getting ☐ Better ☐ Worse ☐ Staying the same?

What do you think is wrong? _____

_____

Other problems you would like to address_____

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Please check the following symptoms which you have had in the past or are experiencing currently:

Head & Face
- ☐ Headaches
- ☐ Dizziness
- ☐ Memory Loss
- ☐ Neck Lump/Swelling
- ☐ Other:_____

Eyes
- ☐ Blurred Vision
- ☐ Eyelid Problem
- ☐ Dry/Itchy Eyes
- ☐ Pain
- ☐ Other:_____

Ears
- ☐ Poor Hearing
- ☐ Earaches
- ☐ Discharges
- ☐ Ringing
- ☐ Other:_____

Nose
- ☐ Frequent Colds
- ☐ Sinus Trouble
- ☐ Nose Bleeds
- ☐ Nasal Obstruction
- ☐ Other:_____

Mouth
- ☐ Gum Problem
- ☐ Teeth Problem
- ☐ Memory Loss
- ☐ Tongue Problem
- ☐ Lip Problem
- ☐ Jaw Problem
- ☐ Unusual Tastes
- ☐ Other:_____

Throat
- ☐ Sore Throat
- ☐ Swollen Glands
- ☐ Hoarseness
- ☐ Difficulty Swallowing
- ☐ Other:_____

Respiratory
- ☐ Difficulty Breathing
- ☐ Pain
- ☐ Chronic Fever
- ☐ Cough
- ☐ Cough Up Phlegm
- ☐ Cough Up Blood
- ☐ Chest Colds
- ☐ Weezing
- ☐ Other:_____

Heart & Thorax
- ☐ Palpitations
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Tightness in Chest
- ☐ Difficulty Lying Flat
- ☐ Chest Pains
- ☐ Other:_____

Circulation
- ☐ Bruise Easily
- ☐ Bleed Easily
- ☐ Leg Cramps
- ☐ Cold Limbs
- ☐ Swollen Feet/Ankles
- ☐ Other:_____

Gastro-Intestinal
- ☐ Weight Loss
- ☐ Belching
- ☐ Excessive Thirst
- ☐ Never Thirsty
- ☐ Excessive Hunger
- ☐ Lack of Appetite
- ☐ Stomach Bloating
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn
- ☐ Difficult Digestion
- ☐ Stomach Pain
- ☐ Colon Problem
- ☐ Hemorrhoids
- ☐ Other:_____

Urination
- ☐ Frequent
- ☐ Difficulty Starting
- ☐ Painful/Burning
- ☐ Night Frequency
- ☐ Blood in Urine
- ☐ Bed Wetting
- ☐ Other:_____

Skin
- ☐ Rashes
- ☐ Dryness/Itching
- ☐ Moles/Lumps That Change
- ☐ Excess Sweat
- ☐ Night Sweat
- ☐ Rarely Sweat
- ☐ Acnes/Boils
- ☐ Other:_____

Neurological
- ☐ Nervousness
- ☐ Fainting
- ☐ Tremors
- ☐ Convulsions
- ☐ Numb or Tingling Limbs
- ☐ Poor Coordination
- ☐ Nerve Pain or Neuralgia
- ☐ Other:_____

Sleep
- ☐ Excessive
- ☐ Insomnia
- ☐ Drowsiness
- ☐ Excess Dreams
- ☐ Other:_____

Moods
- ☐ Annoyed by Little Things
- ☐ Work or Family Problems
- ☐ Cry Often
- ☐ Anger
- ☐ Lack of Concentration
- ☐ Difficulty Making Decisions
- ☐ Anxious/Tense
- ☐ Depression
- ☐ Suicidal
- ☐ Loss of Sexual Drive
- ☐ Shy or Sensitive
- ☐ Other:_____

General

Have you ever had acupuncture or taken chinese herbs before? ☐ Yes ☐ No

What is the most important health change you would like to have occur?_____

_____

_____

_____

Men Only

☐ Weak Urine Stream_____ ☐ Burning or Discharge_____ ☐ Impotence_____

☐ Prostate Problems_____ ☐ Painful Testicles_____ ☐ Other:_____

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Current Medical Status

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Medications (vitamins, prescription or otherwise):_____

_____

Have you ever had your cholesterol level checked?_____ Date(s):_____ Results:_____

Allergies

Drug Allergies (penicillin, etc.):_____

Type of reaction:_____

Allergies to food, pollens, etc.:_____

Type of reaction:_____

Current/Recent Health Care Providers

Name Dates Care Provided

_____

_____

_____

Do any health care providers request follow-up visit here?_____ If yes, name:_____

_____

Date of last physical:_____

Past Medical History

Dates Hospital Diagnosis / Operation Doctor

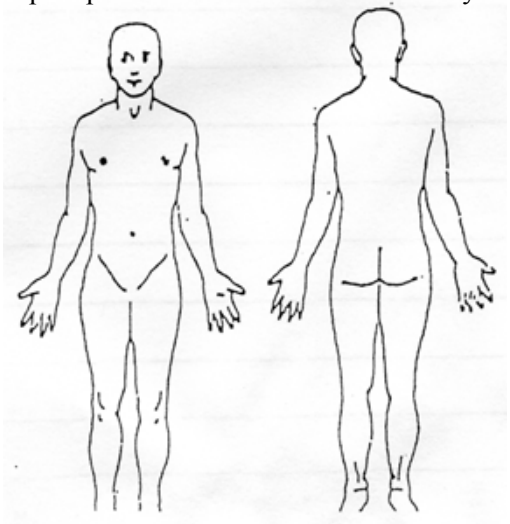
_____

_____

_____

Anything unusual about your birth?_____

If you are in pain please mark the exact location of your pain below:



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Please check the following conditions you have had in the past:

☐ Alcoholism	☐ Emphysema	☐ Hypoglycemia	☐ Pneumonia
☐ Anemia	☐ Eating disorders	☐ Bleeding tendency	☐ Rheumatic fever
☐ ARC/AIDS	☐ Epilepsy	☐ Kidney stones / disease	☐ Scarlet fever
☐ Arteriosclerosis	☐ Gall stones	☐ Liver disease	☐ Stroke
☐ Arthritis	☐ Glaucoma	☐ Lumbago	☐ Thyroid disease
☐ Asthma	☐ Goiter	☐ Malaria	☐ Tuberculosis
☐ Auto accident	☐ Gout	☐ Measles	☐ Tumor
☐ Cancer	☐ Heart disease	☐ Migraine HA	☐ Ulcers
☐ Cold sores	☐ Hepatitis	☐ Mononucleosis	☐ Varicose veins
☐ Diabetes	☐ Hernia	☐ Osteoporosis	☐ Venereal disease
☐ Blood transfusion	☐ High cholesterol	☐ Parasites	☐ Whooping cough
☐ Other	☐ Hives	☐ Pleurisy	

Habits

Dietary preferences/restrictions:_____

Sample of day's menu:

Breakfast: _____

Lunch: _____

Dinner: _____

☐ Tobacco _____ #/Day

☐ Alcohol _____ Drinks/Day

☐ Drugs _____

☐ Caffeine _____ Cups/Day

☐ Water _____ Glasses/Day

☐ Sleep _____ Hours/Night

☐ Exercise _____ Times/Week

Stresses

Stresses (family, work, self, etc.)_____

_____

Family History

Member	Living?	Age?	Important Diseases *(see below)* *Alcoholism, High Blood Pressure, Cancer, Diabetes Heart Disease, Osteoporosis and other addictions, other illnesses*	Cause of Death & Age
Mother				
Father				
Sisters(s)				
Brother (s)				
Maternal Grandmother				
Paternal Grandmother				
Maternal Grandfather				
Paternal Grandfather				
Paternal Aunt(s)				
Maternal Aunt(s)				

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Women Only

Date last period began: _____ Date of last pelvic exam: _____

Date prior period began: _____ Date of last Pap smear: _____

Age of first period: _____ Were the above normal? _____

Have you ever had an abnormal Pap? _____When: _____ Results: _____

Treatment: _____

_____

Are you sexually active? _____ Do you have intercourse? _____ Do you practice safe sex? _____

Are you trying to get pregnant? _____ How long? _____

Current birth control method? _____ How long? _____

Problems with it: _____

_____

Past birth control methods: _____

Normal (not on pills), the number of days from the start of one period to the start of the next: _____

Number of days of flow: _____

Amount of bleeding: _____ Amount of cramps: _____

Premenstrual symptoms: _____

Starting when? _____

Any current changes in your normal pattern? _____

Any bleeding between periods? _____ When? _____

Any unusual pelvic pain, pressure, or fullness? _____ When? Describe: _____

Any unusual vaginal discharge or itching? _____ Describe: _____

How long? _____ Past treatment: _____

Any sexual concerns to discuss? _____

Any past history of tubal infection? _____

Any past history of sexually transmitted disease? _____

Any history of DES exposure? (DES was a drug taken by mothers during pregnancy to prevent miscarriage) _____

_____

Other: _____

_____

Pregnancies: (Including miscarriages and abortions)

Dates	How far along	Sex	Weight	Problems

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Thank you for choosing the Acupuncture Clinic of Napa for your health needs and concerns. We hope your experience meets all of your expectations. Should you have any questions or concerns please do not hesitate to express them to myself or any member of my staff.

Fee Schedule for Acupuncture and Biological Decoding

Initial Consultation and Treatment.....$160.00

Follow Up Treatment with Proposed Plan.....$90.00

Acupuncture Treatment.....$90.00
Extended Acupuncture Treatment.....$100.00
Biological DeCoding.....$120.00
Biological DeCoding With Treatment.....$160.00
10 Minute Personal Consultation.....$40.00
(will apply to original consultation)
Emergency Saturday or Sunday Treatment.....$230.00

Massage Therapy

One half hour.....$45.00
One full hour.....$80.00
One and one half hour.....$115.00

Nutritional Consultation

One full hour.....$120.00
Half hour.....$60.00

Integrative Manual Therapy

50 Minutes.....$85.00
120 Minutes.....$100.00

Office Cancelation Policy

There will be a $40.00 charge for any appointment with less than 24-hour notice. There will be a $90.00 charge for any missed appointment with No-call or No-show status.

Regarding Insurance:

We are happy to give you a statement that can be used for insurance purposes. Your personal insurance is not the responsibility of this office. If you are involved with a Work Compensation or Personal Injury please advise this office prior to your initial visit.

Financial Agreement

I claim full financial responsibility for services rendered at Acupuncture Clinic of Napa. I understand that payment is required in full at the time of service. We gladly accept Visa, Mastercard and personal checks.

Signature of Patient Date

Signature for Minor Child _____

Relationship _____