



1201 Noe Street (@ the corner of 25th Street), San Francisco, CA 94114

www.chinesemedicineworks.com

415.285.0931

Services and Intention

Chinese Medicine Works provides acupuncture and herbal remedies, along with counseling in nutrition and self-care, in a friendly environment. We expect to assist your body and you in a healing process. Welcome.

We Request

Please spend the time to fill out the Patient Information and Self-Assessment Health Profile forms, bringing them with you to your appointment. We know you are busy, but this information will assist us in serving you.

Fees and Schedule

The first appointment costs \$195.00. Follow-up visits are \$110.00 and last about 1 hour. Fees may be paid with cash, check, debit or credit card. We make every attempt to begin treatments on time and hope that you will too. Please leave sufficient time for travel and parking.

Cancellation Policy

We have reserved time and space just for you. If you wish to cancel your appointment, we require at least 48 business hours advance notification, or by 5:00 PM on Thursday for a Monday appointment. Late cancellations or missed appointments will be billed in full to your account.

Let Us Know

We want to know how to best meet your needs. Please inform us of any special considerations. We look forward to your visit and will do our best to be of service.



Chinese Medicine Works

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Personal Information

Name:				Date:	
Address:	city	state	zip		
Phone (home)	(work)	(cell)	Email:		
Preferred contact phone for appointment messages:					
Birth Date:	Age:	Birth Place:	Referred by:		
Status: <input type="checkbox"/> single <input type="checkbox"/> domestic partner <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> widowed <input type="checkbox"/> other					
No. of Children:			Ages:		
Occupation:			Primary Provider or Physician:		
Prior acupuncture treatment <input type="checkbox"/> If yes, for what reason:					

Describe complaints and concerns:

Health & Family History (childhood to present, including illness, injury, surgery, medications):

Aches and pains:

Indigestion: <input type="checkbox"/> gas <input type="checkbox"/> bloating <input type="checkbox"/> reflux <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> other
Environmental Stressors: <input type="checkbox"/> hot <input type="checkbox"/> cold <input type="checkbox"/> humid <input type="checkbox"/> dry <input type="checkbox"/> windy <input type="checkbox"/> pressure change
Chronic Infections: <input type="checkbox"/> Candida <input type="checkbox"/> Herpes <input type="checkbox"/> EBV <input type="checkbox"/> HPV <input type="checkbox"/> HCV <input type="checkbox"/> HIV <input type="checkbox"/> Other
Allergies: <input type="checkbox"/> dust <input type="checkbox"/> pollen <input type="checkbox"/> mold <input type="checkbox"/> cats/dogs <input type="checkbox"/> wheat <input type="checkbox"/> dairy <input type="checkbox"/> peanuts <input type="checkbox"/> soy
<input type="checkbox"/> medications (specify): _____ other: _____
List medications, vitamins, supplements, including dosage:
Typical Diet (cooked/raw):
Breakfast:
Lunch:
Dinner:
Snacks:
Beverages (cold/hot):
Women:
<input type="checkbox"/> PMS <input type="checkbox"/> irregular cycle <input type="checkbox"/> peri-menopausal <input type="checkbox"/> menopausal <input type="checkbox"/> hot flashes
No. of pregnancies: miscarriages: abortions: <input type="checkbox"/> infertility <input type="checkbox"/> abnormal pap <input type="checkbox"/> Other
Men:
<input type="checkbox"/> prostate problems <input type="checkbox"/> urinary disorders <input type="checkbox"/> erectile dysfunction <input type="checkbox"/> infertility <input type="checkbox"/> Other

Additional information:

I understand that appointments not cancelled at least 48 business hours in advance, or by 5 PM on Thursday for a Monday appointment, will be billed to my account.

Signature: _____ Date: _____

For Provider Use:
Acupuncture Treatment _____ Herbs & Supplements _____