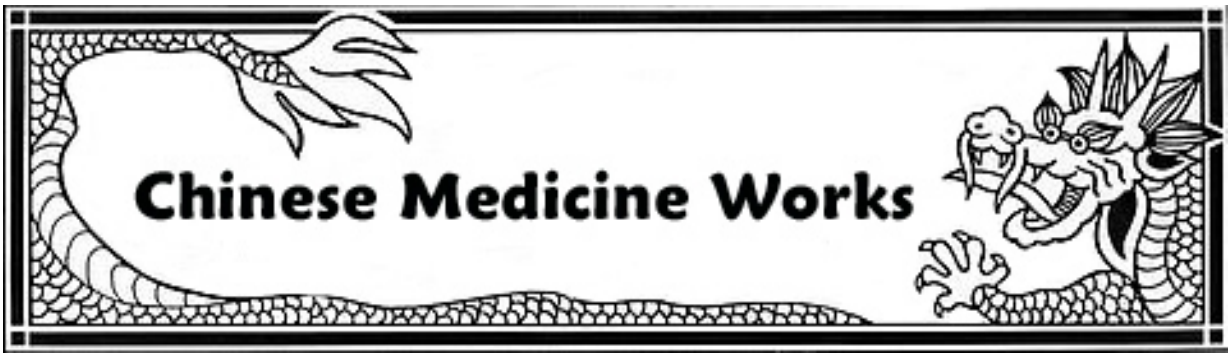

web: www.chinesemedicineworks.com
phone: 415.285.0931
address: 1201 Noe Street, San Francisco, CA 94114

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 fee for the first appointment is $250.00. Follow-up visits are $175.00 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.

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Patient Information Form

Personal Information

Name: _____ Date: ___ /___ /___

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____ Work: _____

Preferred contact phone for appointment messages: ☐ Home ☐ Mobile ☐ Work

Email: _____

Birth Date: _____ Age: ___ Birth Place: _____ Referred by: _____

Relationship Status: ☐single ☐domestic partner ☐married ☐divorced ☐widowed ☐other

No. of Children: _____ Ages: _____ Occupation: _____

Primary Provider or Physician: _____

☐Prior acupuncture treatment? If yes, for what reason: _____

_____

Describe complaints and concerns:

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

Aches and pains:
Indigestion: ☐gas ☐bloating ☐ reflux ☐ constipation ☐ diarrhea ☐ other
Environmental Stressors: ☐ hot ☐ cold ☐ humid ☐ dry ☐ windy ☐ pressure change
Chronic Infections: ☐ Candida ☐ Herpes ☐ EBV ☐ HPV ☐ HCV ☐ HIV ☐ Other: _____

Allergies: ☐ dust ☐ pollen ☐ mold ☐ cats/dogs ☐ wheat ☐ dairy ☐ peanuts ☐ soy
☐ medications (specify): _____other: _____

List medications, vitamins, supplements, including dosage:

Typical Diet (cooked/raw):
Breakfast:
Lunch:
Dinner:
Snacks:
Beverages (cold/hot):

Women:
☐ PMS ☐ irregular cycle ☐ peri-menopausal ☐ menopausal ☐ hot flashes
No. of pregnancies: ____ miscarriages: ___ abortions: ___ ☐ infertility ☐ abnormal pap
☐ Other: _____

Men:
☐ prostate problems ☐ urinary disorders ☐ erectile dysfunction ☐ infertility ☐ Other

Additional information:

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Cancellation Policy Agreement

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**