heart space healing acupuncture

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Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_

Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had acupuncture before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for this referral?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have health insurance? \_\_\_\_\_\_\_\_\_\_\_\_\_ Do they cover acupuncture? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide the following information from your insurance card if you would like us to verify acupuncture benefits.

Insurance Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card holder’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # on back of card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Reason for seeking Acupuncture care?**  How long have you been experiencing this? |

**HEALTH HISTORY**

Please mark any conditions you have had so I have a better idea of your overall health.

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| --- | --- | --- |
| **Musculo-Skeletal Pain**  \_\_hands  \_\_wrists  \_\_elbows  \_\_neck  \_\_back  \_\_legs  \_\_knees  \_\_feet  \_\_joints  **Mental/Emotional**  \_\_mood changes  \_\_depression  \_\_anxiety  \_\_forgetfulness  \_\_stress  \_\_insomnia  \_\_fatigue  \_\_weight gain  \_\_weight loss  \_\_nervousness  **Eyes, Ears, Nose & Throat**  \_\_external eye problems  \_\_vision problems  \_\_external ear problems  \_\_hearing loss  \_\_ringing in ears  \_\_sinus problems  \_\_persistent cough  \_\_difficulty swallowing  \_\_persistent sore throat  \_\_breathing difficulty  \_\_nose bleeds  **Women’s Health**  \_\_irregular menstruation  \_\_painful menstruation  \_\_excessive menstrual flow  \_\_bleeding between periods  \_\_amenorrhea  \_\_breast lumps or pain  \_\_abnormal pap smear  \_\_miscarriage  \_\_yeast infection | **Skin**  \_\_rashes  \_\_change in moles  \_\_hives  \_\_acne  **GastroIntestinal**  \_\_poor appetite  \_\_bloating  \_\_gas  \_\_acid reflux/heartburn  \_\_constipation  \_\_diarrhea  \_\_nausea  \_\_vomiting  \_\_stomach pain  \_\_hemorrhoids  \_\_rectal bleeding  \_\_changes in bowel  \_\_excessive thirst  \_\_excessive hunger  **Cardiovascular**  \_\_chest pain  \_\_palpitations  \_\_high blood pressure  \_\_low blood pressure  \_\_circulation problems  \_\_rapid heartbeat  \_\_ankle swelling  \_\_varicose veins  circulation problems  \_\_rapid heartbeat  \_\_ankle swelling  \_\_varicose veins  **Urinary**  \_\_urinary difficulty  \_\_frequent urination  \_\_urinary incontinence  \_\_painful urination | **Conditions**  \_\_AIDS/HIV  \_\_Alcoholism  \_\_Anemia  \_\_Anorexia/Bulimia  \_\_Appendicitis  \_\_Arthritis  \_\_Asthma  \_\_Bleeding Disorders  \_\_Bronchitis  \_\_Cancer  \_\_Candidiasis  \_\_Cataracts  \_\_Chemical Dependency  \_\_Chronic Fatigue Syndrome  \_\_Cystic Fibrosis  \_\_Diabetes  \_\_Emphysema  \_\_Epilepsy  \_\_Fibromyalgia  \_\_Glaucoma  \_\_Goiter  \_\_Gout  \_\_Heart Disease  \_\_Hepatitis  \_\_Hernia  \_\_Herpes  \_\_High Cholesterol  \_\_Kidney Stones  \_\_Migraine Headaches  \_\_Multiple Sclerosis  \_\_Neuropathy  \_\_Pneumonia  \_\_Pregnancy  \_\_Pre-menstrual Syndrome  \_\_Prostatitis  \_\_Psychiatric Conditions  \_\_Sexually Transmitted Dz  \_\_Stroke  \_\_Tuberculosis  \_\_Ulcers  \_\_Urinary (Bladder) Stones |

Any other conditions I should know about not listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the problem you are seeking care for due to an injury or trauma from an accident? Yes\_\_\_\_ No\_\_\_\_

Is this a work related injury? Yes\_\_\_\_ No\_\_\_\_

Have you seen a doctor/physician for this problem or symptom? Yes\_\_\_\_ No\_\_\_\_

Physician’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have X-rays, MRI, or Lab Tests for this problem? YES \_\_\_\_\_\_\_NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If YES, what were the report findings?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized for this problem? YES \_\_\_\_\_\_\_\_\_NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If YES, please indicate when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any food, herbs, essential oils or drugs?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please List all medications and supplements you are currently taking:

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| --- | --- | --- |
| Medications and/or Supplements | Are you happy with its effectiveness? | Are you experiencing any Side effects? |
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**Cancellation Policy**

Please provide 24 hour notice if you must cancel or change your appointment otherwise there will be a $25 cancellation fee to

cover the time we have set aside for you.

Thank you for this consideration.

Due to our current situation with COVID 19, if you must cancel last minute due to contracting the virus or expose to the virus, there will be no charge but we still would like as much notice as possible. Thank you.

Please sign below stating you understand our cancellation policy.

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