

MATT SCHWARTZ L.Ac.
13259 Moorpark Street, Sherman Oaks, CA 91423
TEL. 818-430-1906

Patient Confidential Information

Name: _____
 First Middle Last

Address: _____
Street City State Zip

Home Phone _____ Business Phone _____

Age _____ Date of Birth ___/___/___ Sex M F * Marital Status S M D W MM DDYY

*Place of Birth _____ *Social Security Number _____ - _____ - _____

*Occupation or profession _____ * Employer _____

Emergency contact: _____
 Name Relation Phone #

 Street City State Zip Code

* *This information is helpful, but optional. All other information is mandatory.*

24 hour cancellation policy-

In order to maintain the integrity of Golden Monkey Healing we must request that all cancellations be made with a minimum of 24- hour notice. Failure to provide 24- hour notice or a failure to show will result in your account being charged for the visitation at our standard fee.

-Thank you for your understanding.

X _____
Signature of Patient Date

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by Matt Schwartz. I understand that acupuncturists practicing in the state of California are primary care providers and that regular primary care by a licensed physician in addition is an important choice that is strongly recommended.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the Chinese Medical Clinic as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____

SIGN BELOW ONLY IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION

I requested and received, in substantial detail, further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment. I give my permission and consent to treatment.

X _____
Patient's Signature Date

X _____
Explained by me and signed in my presence Date

Medical History Questionnaire

Please complete the following as accurately as possible.

Name: **X** _____

Date: _____

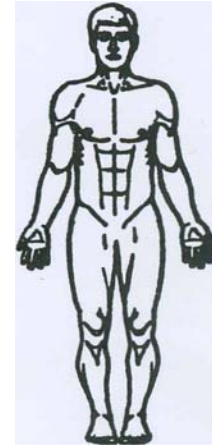
Present Illness:

What is your chief complaint?

Mark with an X where you feel pain or discomfort.

When did this condition begin?

What treatment have you received already?



Medical History:

What surgeries have you had? When did you have them?

What other serious injuries or illnesses have you had?

Do you have any allergies that you know of?

What medications are you taking?



Which, if any, of your blood relatives have had any of the following?

- Stroke
- Cancer
- Heart Disease
- Tuberculosis
- Bleeding disorders
- Diabetes
- High blood pressure

Menstrual History:

Age of your first period: _____

Vaginal discharge: _____

Length of cycle, day 1 to day 1 _____

Length of flow (days): _____

Date of your last period: _____

Do you believe you are pregnant? Yes__ No__

Recreational Substance Usage:

History of smoking? _____

-how many years? _____

-how many per day? _____

History of smokeless tobacco use? ... _____

History of drinking alcohol? _____

-how many drinks/week? .. _____

History of recreational drug use? _____

How many cups of coffee/day? _____

How many sodas/day? _____

Name: _____

Date: _____

CHECK ANY CURRENT CONDITIONS OR THOSE THAT YOU HAVE HAD IN THE PAST
(please write the word "Past" next to those conditions which you have ONLY had in the past and which are no longer present)

HEAD AND NECK:

- ___ Dizziness
- ___ Fainting
- ___ Neck Stiffness
- ___ Enlarged lymph glands
- ___ Headaches
- ___ Other

EARS:

- ___ Infection
- ___ Ringing
- ___ Decreased hearing
- ___ Other

EYES:

- ___ Blurred vision
- ___ Visual changes
- ___ Poor night vision
- ___ Spots/Floaters
- ___ Eye inflammation/Styes
- ___ Other

NOSE, THROAT & MOUTH:

- ___ Bleeding
- ___ Sinus infection
- ___ Hay fever or allergies
- ___ Sore throat
- ___ Hoarseness
- ___ Changes in taste
- ___ Difficulty swallowing
- ___ Changes in smell
- ___ Oral ulcers/Canker sores
- ___ Other

SKIN:

- ___ Hives
- ___ Rashes
- ___ Eczema
- ___ Psoriasis
- ___ Seborrhea
- ___ Night sweating
- ___ Excess sweating
- ___ Dryness
- ___ Bruises easily
- ___ Changes in moles or lumps
- ___ Other

NEUROLOGICAL:

- ___ Numbness or tingling of limbs
- ___ Seizures
- ___ Tremors
- ___ Pain
- ___ Paralysis
- ___ Epilepsy or Convulsions
- ___ Other

INFECTION SCREENING:

- ___ HIV/AIDS, or HIV risks: Self or partner
- ___ TB: Self or household
- ___ Hepatitis, or Hepatitis risk: Self or partner
- ___ History of sexually transmitted diseases: Self or partner:
- ___ Gonorrhea
- ___ Chlamydia
- ___ Syphilis
- ___ Genital warts
- ___ Herpes (oral)
- ___ Herpes (genital)

RESPIRATORY:

- ___ Chronic cough
- ___ Coughing up blood
- ___ Coughing up phlegm frequently
- ___ Difficulty breathing
- ___ Wheezing/Asthma
- ___ Frequent Colds
- ___ Emphysema
- ___ Pneumonia repeatedly
- ___ Other

CARDIOVASCULAR:

- ___ Palpitations
- ___ Chest pain or tightness
- ___ Rapid heart beat
- ___ Irregular heart beat
- ___ Heart Disease
- ___ Poor circulation
- ___ Swelling of ankles
- ___ Phlebitis
- ___ Cold hands/feet
- ___ Cardiac Pacemaker
- ___ High blood pressure
- ___ Stroke
- ___ Other

GASTROINTESTINAL:

- ___ Indigestion
- ___ Nausea
- ___ Stomach pain
- ___ Irritable bowel disease
- ___ Colitis
- ___ Crohn's Disease
- ___ Pancreatitis
- ___ Celiac Disease
- ___ Recent change in bowel habits
- ___ Diarrhea (___ stools/day)
- ___ Constipation (___ stools/week)
- ___ Dry, hard stools
- ___ Soft, difficult, sticky stools
- ___ Irregularly or poorly-formed stools
- ___ Poor appetite
- ___ Excessive hunger
- ___ Blood in stool or black stools
- ___ Hemorrhoids
- ___ --with pain or blood
- ___ Gall bladder disorder
- ___ Vomiting blood
- ___ Peptic Ulcer
- ___ Recent change in weight
- ___ Food cravings
- ___ Other

MUSCLES AND JOINTS:

- ___ Joint disorder
- ___ Sore muscles
- ___ Weak muscles
- ___ Difficulty walking
- ___ Spinal curvature
- ___ Backache
- ___ Back pain
- ___ Fibromyalgia
- ___ Other

MALE:

- ___ Pain/itching of genitalia
- ___ Genital lesions/discharge
- ___ Impotence
- ___ Premature ejaculation
- ___ Prostate problems
- ___ Infertility (e.g., abnormal sperm)
- ___ Other

FEMALE:

- ___ Frequent vaginal infections
- ___ Infertility
- ___ Pain/itching of genitalia
- ___ Genital lesions/discharge
- ___ Pelvic inflammatory disease
- ___ Abnormal Pap smear
- ___ Irregular periods
- ___ Emotional changes with menses
- ___ Clots with menses
- ___ Painful menstrual periods/cramps
- ___ Premenstrual Syndrome
- ___ Abnormal bleeding
- ___ Menopausal symptoms (hot flashes, etc.)
- ___ Breast lumps/cysts
- ___ Breast swelling and/or pain
- ___ Other

URINARY:

- ___ Frequent urinary tract/bladder infections
- ___ Weak urinary stream
- ___ Recent change in bladder habits
- ___ Kidney Disease
- ___ Other

GENERAL:

- ___ Fatigue
- ___ Thirst
- ___ Aversion to cold
- ___ Insomnia
- ___ Frequent dreams/nightmares
- ___ Depression
- ___ Agitation
- ___ Irritability
- ___ History of psychiatric treatment
- ___ Poor memory
- ___ Difficulty concentrating
- ___ Frequent night urination (___ X)
- ___ Frequent day urination (___ X)
- ___ Sores that don't heal
- ___ Congenital abnormalities
- ___ Surgical implants
- ___ Unusual bleeding or discharge
- ___ Jaundice
- ___ Hernia
- ___ Epstein Barr virus (EBV)
- ___ Rheumatic Fever
- ___ Diabetes mellitus
- ___ Thyroid Disorder
- ___ Cancer
- ___ Anemia or other blood disorder
- ___ Lupus erythematosus
- ___ Other

PLEASE STOP HERE!