YX Medical Group, Inc

I. General Patient Information

Name: _____ _____
(First) (Last)

Date of Birth: _____/_____/_____ Sex: ☐ Male / ☐ Female

Address: _____ City_____ State_____ Zip Code:_____

Home Phone#: (_____)_____ Cell Phone#: (_____)_____

Email Address: _____ SS#: _____

DL#: _____ Occupation: _____ Employer: _____

Is this your first time getting acupuncture? ☐ Yes / ☐ No

How did you hear about us? ☐ Friend referral _____ ☐ Lighthouse

☐ Weekly LaLaLa ☐ Vivi Navigation ☐ Yelp ☐ Our Website

Is this visit due to an auto accident? ☐ Yes / ☐ No

Do you have health insurance? ☐ Yes / ☐ No Name of Carrier: _____

Emergency Contact : _____

Relationship: _____ Phone#: (_____)_____

I hereby certify that to the best of my knowledge, all statements contained hereon are true.
I understand that I am directly responsible for all charges incurred by medical services for myself and my dependents regardless of insurance coverage.
I furthermore agree to pay legal, interests, collection expense and attorney's fee should it become necessary to assign any amount I may own for collections.
I hereby authorize YX Medical Group, Inc to release information requested by my insurance company for service rendered.
I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO YX MEDICAL GROUP INC, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.
I have read and understood the "HIPAA Notice of Privacy Practice" and how my medical information may be used and disclosed and how I can get access to this information.
I have read and understood the "Patient Policies" and agree with the policies.
I hereby authorize the Acupuncturist to treat my condition as she/he deems appropriate.
I fully understand that this agreement and consent will continue until cancelled by me in writing.

Date: _____ Patient or Guarantor's Signature _____

HEALTH HISTORY QUESTIONNAIRE

Information for your Acupuncturists

Important: Complete this document as thoroughly as possible. All information is strictly confidential.

II. Patient Medical History

Please describe your current health problems(s):

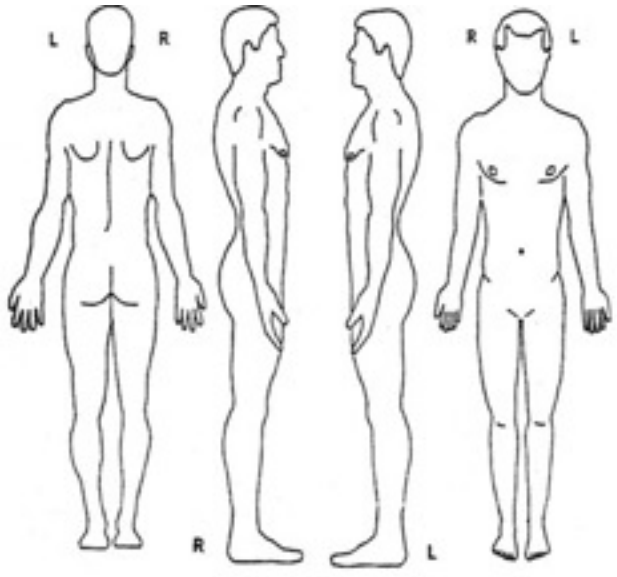
1. _____ 2. _____

3. _____ 4. _____

5. _____ Additional: _____

Are you currently taking pain medication or blood thinners? (including aspirin) ☐ Yes / ☐ No

INSTRUCTIONS: Please mark the areas on you body where you feel your PAIN. If the pain radiates, draw an arrow from where the pain starts to where it stops. Please extend the arrows as far as the pain travels.



Is the pain:

☐ Sharp ☐ Burning ☐ Aching

☐ Cramping ☐ Dull ☐ Moving

☐ Fixed ☐ Other _____

Do the following improve the pain?

☐ Pressure ☐ Cold ☐ Heat

☐ Exercise ☐ Other _____

Do the following worsen the pain?

☐ Pressure ☐ Cold ☐ Heat

☐ Other _____

Circle your current pain levels:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**

In the past week, how much has your pain interfered with your daily activities?

No Interference 0 1 2 3 4 5 6 7 8 9 10 **Unable to carry on any activities**

- **I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.**

Date: _____ Patient or Guarantor's Signature _____