Dr Tirtha Mendake. L.Ac., D.C., M.S., M.B.B.S

Initial Health History Form

Please complete this document as thoroughly as possible; it will help me assess & diagnose your condition. All information is strictly confidential.

PATIENT INFORMATION ***(Please Print and complete in full)***

Today's Date ……

Name ……

Address ……

Phone No. ……. Email Address ……

May we contact you a) By Phone ☐ b) Email ☐

Birth Date ……. Age …….. Social Security # (optional) ……

Gender - M ☐ F ☐ How would you like to be addressed? ……

Marital Status …… Children …… Their ages ……

Emergency Contact …… Relationship …… Phone No. ……

Referred to our Clinic By ……

Occupation …… Employer's Name …… Phone No ……

Primary Insurance …… Subscriber ID…… Policy Holder's Name ……

Relationship ……

Under 18 Responsible Party Information

Name …… Relationship to the Patient ……

Health Care Providers – Please list those you work with

Physician's - G P / Primary Care …… Specialist ……

Phone No …… Date of last visit ……

Physician's Address ……

Previous Experience with Acupuncture …… Chiropractic ……

Practitioner's Name …… Results ……

How did you hear about our office? ……

Major Complaint(s) in descending order of significance

1 …….. 4 ……

2 …….. 5 ……

3 …….. 6 ……

How do these conditions impair your daily activities? …….

Is your health complaint related to your occupation or a car accident? …….

How and when did the conditions begin? ……

State of the problem since it first occurred - Gotten worse ☐ Better ☐ Same ☐

What personal and professional care have you received for this problem? Was it helpful? ……

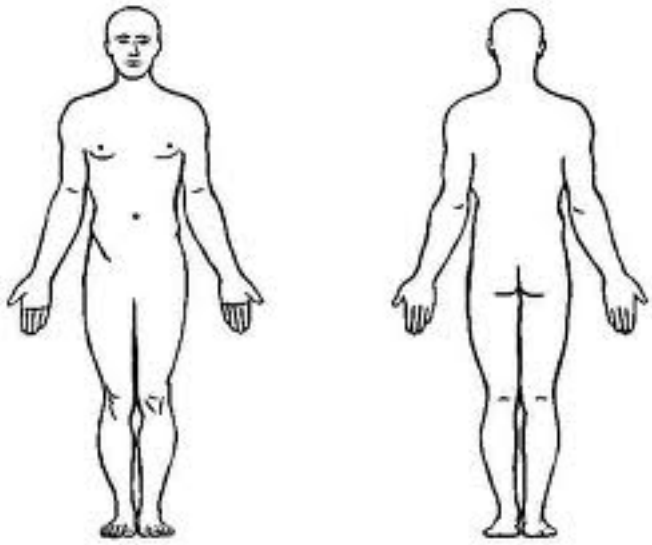
Are you presently being treated for any medical condition? Please describe …….

If you are experiencing any Pain ☐ Discomfort ☐ Injury ☐

Please clearly mark any areas of pain with x

Please describe the cause of injury here - ……

……



Dr. Tirtha Mendake. L.Ac., D.C., M.S., M.B.B.S
300, Brannan Street, Suite 302, San Francisco, CA 94107

Patient Medical History

Any Medical Conditions ……..

Check the conditions that apply to your past medical history

Diabetes	Stroke	Tuberculosis	Kidney Stones	Eczema
Heart Disease	Asthma	Hepatitis	Frequent UTI	Migraines
High Blood pressure	Pneumonia	Jaundice	Cancer Anemia	Rheumatic Fever
Other heart illness	Emphysema	Gall Stones	Allergies	Shingles
Bleeding Tendency	Anemia	Nervous Disorder	Glaucoma	Varicose Veins
Thyroid Disorder	Mononucleosis	Lyme's Disease	Multiple Sclerosis	Paralysis
Veneral Disease	Measles	Mumps	Chicken Pox	Polio
Meningitis	Epilepsy	HIV / AIDS	Ulcer	Gastritis
STD	Fractures			

History of Hospitalization ……

Surgeries ……..

Serious injuries or accidents ……..

Family History (List any family physical or mental illness and age of death)

Mother ……..

Father ……..

Grandparents ……

Siblings ……

Children ……

Medication (Check after the medications you are currently taking, please list specific medications, if possible)

Blood Thinners	Blood Pressure Medication	Sleep Medication	Tranquilizers
Pain Medications	Laxatives	Cortisone	Antacid

Herbs / Supplements

Name …….. Reason …….. Dosage duration ……

Name …….. Reason …….. Dosage duration ……

Name …….. Reason …….. Dosage duration ……

Name …….. Reason …….. Dosage duration ……

Lifestyle Habits

Describe your typical daily diet

Breakfast …….. Lunch ……

Dinner …… Snacks ……..

Special Diet …… 3 worst foods you eat ……..

Do You	Yes	No	
Average 6-8 hours of sleep?			What is the major source of joy in your life?
Have a supportive relationship?			
Have a history of abuse?			
Enjoy your work?			What is the major source of stress in your life?
Take vacations?			
Spend time outside			
Exercise?			Describe exercise
Watch TV ?			How many hours weekly ?
Read Books?			How many hours weekly ?
Computer Games / Browsing?			How many hours weekly ?
Spiritual / religious practice?			Describe?
Smoke cigarettes?			How many per day?
Smoke cigarettes in the past?			How many years? How many per day?
Eat out often?			How many meals a week?
Drink Coffee?			How many cups per day?
Drink Tea?			How many cups per day?
Drink Soft drinks?			How many per day?
Use Sugar?			How much?
Drink alcohol?			How many drinks per week?
Use recreational drugs?			What and how often?
Have an addiction?			To what and How long?
Been outside the U.S. in the past 12 months?			Where?

What are your goals for your health? …….

Please circle your level of commitment to correcting your health issues? (10 = Highest Level)

1 2 3 4 5 6 7 8 9 10

Tests and Immunizations

Please list the date of your most recent visit:

Chest X-ray	Sigmoidoscopy	EKG	Stool Blood test
Mammogram	TB Skin Test	Pap Smear	Complete Physical
GI Series	Flu Shot	Pneumonia Shot	Other

Please check the appropriate conditions in the following list of symptoms, if you are currently having the symptoms. If you have had symptoms in the past and do not experience it now, just write **P** next to it.

Overall Energy

Low Energy	Overall achy feeling in body	General Sensation of heaviness in the body
General weakness	Low libido	Sleepy after eating food
Feels worse after exercise	Excessive libido	

Overall Temperature

Cold Body Temperature	Afternoon hot flushes	Hot flashes anytime of the day or night
Cold Sensation in Knees	Night Sweats	Hot body temperature
Can get chilled to the bone	Heat in the hands, feet and chest	Alternative fevers and chills
Excessive thirst	Easy to perspire	Excessive perspiration
Rarely Perspire even during exercising		

Digestion

Low Appetite	Fatigue after meals	Fullness after meals	Passing gas
Ulcers / GRED	Excessive Appetite	Abrupt weight loss	Hiccoughs
Stomach pain	Acid reflux	Heartburn	Gurgling noise in stomach
Mouth sores	Bad breath	Nausea	Feel better after eating
Vomiting	Abdominal bloating	Belching	Feel worse after eating

Liver / Gall bladder

Depression	Stress	Do you crave sour taste	Cold hand / Cold feet
Frustrated	Bitter taste in mouth	Frequent headaches	Chest tightness
Dizziness	Blurred Vision	Pain in the rib cage	Feeling of lump in throat
Seizures	Tremors	Clenching teeth at night	Muscle cramping & twitching
PMS	Soft and brittle nails	Red and dry itchy eyes	Neck and shoulder pain
Irritability	Easily Angry		

Heart / Small Intestine

Palpitations	Chest Pains / Tightness	High Blood pressure	Difficulty staying asleep
Anxiety	Restlessness	Insomnia	Difficulty falling asleep
Low BP	Wakes up many times	Mouth sores	Varicose veins
Vivid dreams	Nightmares	Easily startled	Dark urine

Spleen / Stomach

Body heaviness	Edema (hands, feet)	Muscles often feel tired	Energy level 1-10 (low to high)
Nausea	Gas belching	Excess or low appetite	Sweet taste in mouth
Lack of taste	Organ prolapse	Excess of lack of thirst	Hard to get up in the morning
Vomiting	Reduced thirst	Easily bruising or bleeding	Hemorrhoids
Bad breath	Brain fog	Tendency to gain weight	Do you crave sweet
Over Drinking	Worry		

Lung / Large Intestine

Difficulty breathing	Shortness of breath	Cough	Cough with sputum
Chest tightness	Asthma	Dry Skin	Cracks on hand and feet
Chronic sadness	Melancholy	Sleep Apnea	Nasal discharge
Post nasal drip	Dry mouth and nose	Allergies	Catches cold easily
Do you crave pungent or spicy	Grief / sadness		

Kidney / Urinary Bladder

Frequent urination	Painful urination	Burning urination	Urgent urination
Color - light yellow	Color –dark yellow	Difficult urination	Strong Odor
Waking up during the night to urinate	Lack of bladder control	Memory problems	Knee pain
Weakness	Hair loss	Easily startled and fearful	Graying hair
Low sex drive	Excessive sex drive	Dark circle under eyes	Hearing Problem
Cavities	Do you crave salt		

ENT

Seasonal Allergies	Sinus Congestion	Headache	Sore throat
Difficulty swallowing	Earache	Ringing in ears	

Women only

Could you be pregnant ?	How many weeks?	No. of pregnancies	Age at menstruation
Age at menopause			

Men Only

Swollen testes	Testicular pain	Impotence	Erectile dysfunction
Premature ejaculation	Enlarged prostate	Others	

Anything not mentioned that you think would be relevant to your diagnosis and treatment?

……..

……..

……..

……..

……..

……..

Patient's Signature …….. Date ……..

Our office policies

The following are our office policies. They will help us work together smoothly and be productive. Kindly read them carefully.

Cancellation Policy

In the event that you must cancel your appointment, please give us at least a 24 hour notice. We will try to reschedule you the same week so that you do not miss your appointment. If you do not show up for your appointment or cancel your appointment with less than 24 hour notice, you shall be charged full fee for the session.

Late Policy

If you are going to be late, please call and let us know. We will wait until the time we agree upon. If you are unable to make by the agreed upon time, your appointment shall be cancelled and we will charge you for the session. We will try our best to accommodate you, however, we have patients scheduled before and after you.

Phone calls and emails

You may phone or email us when necessary and we shall respond within 24 hours. Our phone calls and emails are limited to 10 min of our time. All contacts beyond 10 min shall be considered a session and billed at the flat rate of $35.

Cell phones

Kindly turn of your cell phone when you are in the session. Our intention is to create healing environment for you when your energies will be rejuvenated. Any external distraction will only serve to hinder the energetic process of healing.

Fees

It is our policy that you pay entire session fee or copay at the time of the session. If you would like to arrange another payment option, please discuss with us.

Your participation

We are your partners in health care. Please comply with our health recommendations and our treatment plan.

Agreement

I have read and understood the clinic policies. I agree to all the above treatment terms and conditions.

Patient Signature …….. Date ……

Insurance Responsibility Statement Having insurance is not a substitute for payment. Our office will provide insurance billing services for you if you so desire as a courtesy. Many companies have fixed allowances or percentages based on your contract with them, not with our clinic. It is your responsibility to pay the deductible, co-payment, and any other balances not paid by your insurance. We will assist you in billing your insurance company as much as possible. However, you are responsible for your bill.

Assignment and Release

I hereby assign my insurance benefits to be paid directly to the provider of service. I understand that I am financially responsible for any non-covered services. I also authorize the provider to release any information required to process any claims.

Signed …….. Date ……..

Patient's Signature …….. Date ……..

Notice of Privacy Practices

Our Pledge Regarding Medical Information:

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information. This notice will remain in effect until it is replaced or amended by changes in law.

Use and Disclosure of Your Medical Information

We gather personal health information in several ways. This information comes from you, from other healthcare providers, and from third party payers. This section describes different ways that we use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us. We may use and disclose your medical information in the following ways:

For treatment I For payment I For healthcare operations I When required by law

This office will not use your health information for marketing communications without your written authorization. However, this office may send birthday cards, newsletters and appointment reminders, by telephone calls or mail.

Patient Rights

Upon written request, you have the right to access, review or receive copies of your health care records. There is a copy fee of $15 and with 10 working days to process it.
Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
You have the right to request that this office place additional restrictions on disclosure of your protected health information.
You have the right to request that we amend your protected health information; the request must be in writing.
You have the right to receive all notices in writing.

If you have questions, complaints or want more information, please contact this office.
Contact: Dr. Tirtha Mendake, **Telephone** 415-578-8781, **Address**: 300 Brannan Street, San Francisco. CA 94107
Send written complaints to the U.S. Department of Health and Human Services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, …….. , have read, reviewed, understand and agree to the statement of the Privacy Practices for healthcare services in this office. This practice has attempted to provide each patient with a statement of Privacy Practices.

Patient Signature …….. Date …….