



SAN FRANCISCO
INTEGRATIVE MEDICINE

Welcome to the office of San Francisco Integrative Medicine & Acupuncture, Inc. We know that you have many choices when looking for a health care practitioner, and we are quite happy you have chosen us. You can be sure that your treatments here will be given with the utmost care, with your comfort and safety foremost on our minds.

We welcome any and all questions you may have about your treatments, as well as questions or comments related to our atmosphere or billing practices.

Please note that price for visits where payment is collected same day (non-insurance) are as follows:

- Initial Visit Exam, Consultation, and Treatment - \$145
- Acupuncture Follow-Up Visit(s) - \$95
- Cupping, Graston, Gua Sha Only - \$65
- Dry Needling/Motor Point Therapy - \$165
- Comprehensive Lab Review - \$150
- Micro-Needling with LED Light Therapy - \$350

For a full list of our services, please refer to our website www.integrativemedicinesf.com

If you would like to use insurance, please contact the office by phone or email with your insurance information.

Herbal formulas are not included in these fees. You can purchase herbal formulas from our office or from a health food store, etc. – when purchasing herbs, make sure that the company is GMP (Good Manufacturing Process) certified. We have a full herbal pharmacy here using only companies with the highest quality controls.

Please allow up to an hour and a half for your first visit. Thanks again for allowing us to be a part of your health care team!

Sincerely,

Elanita Korian, L.Ac., M.S.

Dr. Jennifer Bezbek, DAOM, LAc

Dr. Laurie Terzo, DAOM, L.Ac., FABORM



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Welcome and thank you for choosing San Francisco Integrative Medicine. Our goal is to help you achieve your optimum health and wellness. This is a **confidential** questionnaire to help me determine the best treatment plan for you. If you have any questions please ask. Thank you.

Personal Information

Name _____ Date _____
Home Address _____
City _____ State _____ Zip _____
Primary Phone _____ Email _____
Occupation _____ Work Phone _____
Person responsible for your account _____
Emergency Contact: Name _____ Phone _____
Sex: Male Female Trans (__MTF __FTM) Gender Queer Birthdate _____ Age _____
Marital Status: Married Single Divorced Widowed Partnered Number of Children _____
Have you received acupuncture therapy before? Yes No
When? _____ With whom? _____
Who should we thank for referring you? _____

Please indicate any significant illnesses you or a blood relative (grandparent, parent, sibling) have had:

Illness	You	Relative	Approx. Date	Illness	You	Relative	Approx. Date
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Press	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infectious Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

Sexually Transmitted Diseases: Gonorrhea, Syphilis, HIV, HPV, Chlamydia, Herpes, Other _____

List any medications and supplements you are currently taking. Continue on back if necessary.

Medicine	Dose	Reason	How Long	Prescribed By	Date of Last Checkup
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Check box if any of the following statements are true:

- I have known allergies
- I am taking Coumadin/Warfarin
- I have a pacemaker
- I am taking Lithium

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much
Coffee/ Black tea	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Non-Medicinal Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Soda	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____	Water Intake	<input type="checkbox"/>	<input type="checkbox"/>	_____

OB/GYN History

Age of 1st period (menarche) _____ Are you pregnant Yes No # of pregnancies _____
Age of Last period (menopause) _____ # of live births _____ # of abortions _____ # of miscarriages _____
of days between periods _____ Date of last gynecologic exam _____ Pap smear _____
of days of flow _____ Mammogram _____ Bone Density Scan _____
Color of Flow _____ Results _____
Clots Yes No Color: _____ Avg. # of Pads/tampons per days 1st ___ 2nd ___ 3rd ___ 4th ___ 5th ___ + _____
Have you been diagnosed with: Fibroids Fibrocystic Breasts Endometriosis Ovarian Cysts PID
Other _____
Birth Control: None Barriers Birth Control Pills IUD Spermicides Condoms
Location of Menstrual Pain: Lower abdomen Lower back Thighs Other _____

Nature of Pain (indicate before, during, after)

Cramping _____ Stabbing _____
Burning _____ Aching _____
Dull _____ Bloating _____
Consistent _____ Intermittent _____
Bearing Down Sensation _____

Other symptoms related to menses:

Ravenous Appetite Vaginal Dryness Headache
 Poor Appetite Constipation Mood Swings
 Insomnia Swollen Breasts Diarrhea
 Increased Libido Hot Flashes Night Sweats
 Decreased Libido Nausea Discharge

Urogenital History

Date of last prostate checkup _____ PSA Results _____
Manual prostate exam results _____ Lab Results _____
Frequency of Urination: Daytime _____ Nighttime _____ Color of urine Clear Murky Odor _____

Symptoms Related to Prostate:

Prostate Problems Delayed Stream Post Void Dribbling Incontinence
 Retention of Urine Decreased Force of Stream Increased Libido Decreased Libido
 Premature Ejaculation Impotence Back Pain Groin Pain
 Testicular Pain Erectile Dysfunction BPH/Enlarged Prostate

Symptom Survey

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows in the space to the left.

No mark () = never experience, Check Mark (✓) = sometimes experience, Plus Sign (+) = frequently experience

<input type="checkbox"/> Lack of Appetite	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Eye issues	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Excessive appetite	<input type="checkbox"/> Chest pains	<input type="checkbox"/> Jaundice (yellowish skin/eyes)	<input type="checkbox"/> Edema
<input type="checkbox"/> Loose stool or diarrhea	<input type="checkbox"/> Sciatic Pain	<input type="checkbox"/> Difficulty digesting oily foods	<input type="checkbox"/> Blood in stool
<input type="checkbox"/> Digestive problems	<input type="checkbox"/> Headaches	<input type="checkbox"/> Gall stones	<input type="checkbox"/> Black tarry stool
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Pain or coldness in genital area	<input type="checkbox"/> Light Colored Stools	<input type="checkbox"/> Easily bruised
<input type="checkbox"/> Belching	<input type="checkbox"/> Cough	<input type="checkbox"/> Soft or brittle nails	<input type="checkbox"/> Difficult to stop bleeding
<input type="checkbox"/> Heartburn/reflux	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Easily angered or agitated	<input type="checkbox"/> Asthma
<input type="checkbox"/> Feeling of food retention in stomach	<input type="checkbox"/> Decreased sense of smell	<input type="checkbox"/> Difficulty in making plans or decisions	<input type="checkbox"/> Tendency to catch colds easily
<input type="checkbox"/> Tendency to become obsessive in work/relationship	<input type="checkbox"/> Nasal problems	<input type="checkbox"/> Spasms or twitching muscles	<input type="checkbox"/> Intolerance to weather changes
<input type="checkbox"/> Insomnia, difficulty sleeping	<input type="checkbox"/> Skin problems	<input type="checkbox"/> Low back pain	<input type="checkbox"/> Allergies
<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Feeling of claustrophobia	<input type="checkbox"/> Knee problems	<input type="checkbox"/> Hay fever
<input type="checkbox"/> Cold hands/feet	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Nightmares	<input type="checkbox"/> Colitis or diverticulitis	<input type="checkbox"/> Ear ringing	<input type="checkbox"/> Tendency to faint easily
<input type="checkbox"/> Mentally restless	<input type="checkbox"/> Constipation	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> High cholesterol levels
<input type="checkbox"/> Laughing for no apparent reason	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Hair loss	<input type="checkbox"/> Sudden weight loss
<input type="checkbox"/> Angina pains	<input type="checkbox"/> Recent antibiotic use	<input type="checkbox"/> Decreased sex drive	<input type="checkbox"/> Other _____
		<input type="checkbox"/> Urinary problems	

Clinical Notes

HPI:

What are the main health problems for which you are seeking treatment?

What other forms of treatment have you sought?

List any other health problems you now have.

List any allergies, food sensitivities or food cravings that you have.

List any accidents, surgeries or hospitalizations (include date).

For Office Use

How do you FEEL about the following areas of your life?

Please check the appropriate boxes and indicates any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Your Comments
Significant Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>

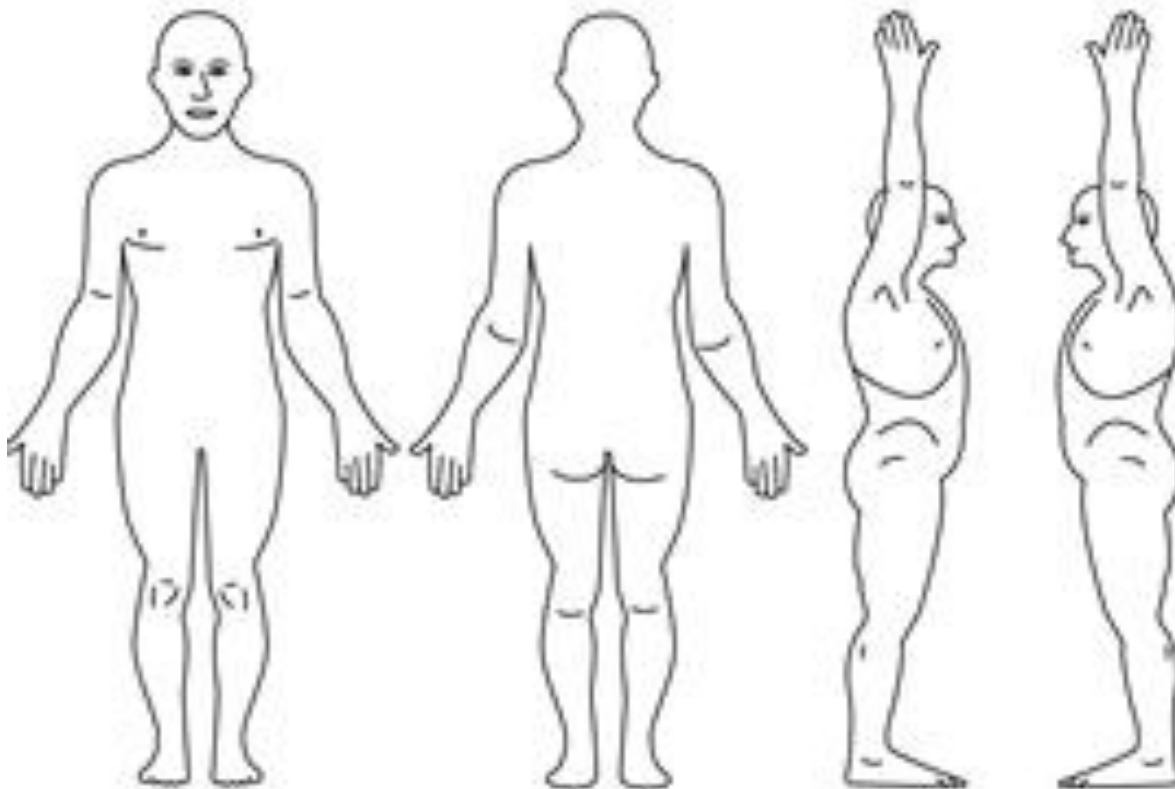
Which of the follow is most important to you? (choose one)

- Unconditional love
- Feeling understood
- Feeling respected and appreciated
- Feeling that everything is going to be okay
- Having a sense of direction

Other information you would like to report/may be relevant to your medical history?

Areas of Pain

Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing



Sharp and Stabbing = +++++
 Dull and Achy = VVVVV
 Pins and Needles = 00000
 Numbness = /////
 Heat = HHHH
 Cold = CCCCC

Please check the appropriate # to describe your present pain level with 0 being Normal/or no pain; and 10 being sever pain

Area of Pain	Normal		Mildly in Pain			Moderate Pain			Severe Pain				
Neck	0	1	2	3	4	5	6	7	8	9	10	C	I
Middle Back	0	1	2	3	4	5	6	7	8	9	10	C	I
Lower Back	0	1	2	3	4	5	6	7	8	9	10	C	I
Hip(s) L R	0	1	2	3	4	5	6	7	8	9	10	C	I
Shoulder(s) L R	0	1	2	3	4	5	6	7	8	9	10	C	I
Arm (s) L R	0	1	2	3	4	5	6	7	8	9	10	C	I
Leg(s) L R	0	1	2	3	4	5	6	7	8	9	10	C	I
Headaches	0	1	2	3	4	5	6	7	8	9	10	C	I
Other:	0	1	2	3	4	5	6	7	8	9	10	C	I
Other:	0	1	2	3	4	5	6	7	8	9	10	C	I
Other:	0	1	2	3	4	5	6	7	8	9	10	C	I