Sharareh Daghighi, D.A.O.M, L.Ac
16260 Ventura Blvd, Suite LL16
Encino, CA 91436
Phone: (818) 642-3512
www.acuandherbs.com

Patient Information:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____/_____/_____ Social Security # _____-_____-_____ Sex: F ☐ M ☐

Home Address: _____
Street Apt# City State Zip code

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

Marital Status: Single ☐ / Married ☐ / Other ☐ Email Address:_____

Employer: _____ Title: _____ Phone: (_____) _____

Employer's Address: _____
Street Suite# City State Zip Code

Family Physician: _____ Phone: (____) _____

Spouse Information:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____/_____/_____ Social Security #_____-_____-_____ Sex: F ☐ M ☐

Phone Number: (_____) _____

Referring Physician name and number:
_____

Referring friends name:_____

Found us on: Internet: _____ Insurance website:_____

This will constitute authorization for treatment by Sharareh Daghighi, L.Ac for my child/ward or me. In the event of default, patient responsible party agrees to pay all collections and attorney fees. I hereby authorize the physician to furnish information to insurance carriers concerning this illness/accident, and hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by my insurance. A copy of this authorization shall be considered as valid as the original.

Signature: _____ Date: _____

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Age at which menses began _____

Are your periods painful?
Yes ☐ No ☐

How many days do you normally bleed?
_____

How heavy is the bleeding? Light ☐
Normal ☐ Heavy ☐

What color is the blood? Light red ☐
Red ☐ Dark red ☐
Purple ☐ Brown ☐ Black ☐

Is there clotting?
Yes ☐ No ☐

Does your face break out before or during your period?
Yes ☐ No ☐

Do your breasts become tender pre-menstrually?
Yes ☐ No ☐

Do you bleed or spot between periods?
Yes ☐ No ☐

Are your menstrual cycles spaced irregularly?
Yes ☐ No ☐

How many days are there from one period to the next?
_____

Date of last menstrual period
_____

How many pregnancies have you had?
_____

How many children do you have?
_____

How many abortions have you had?
_____

How many miscarriages have you had?
_____

How many times has a D & C been performed? _____

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Have you ever had an abnormal pap smear?

Yes ☐ No ☐

Have you ever had a cervical biopsy, operation, cauterization or conization?

Yes ☐ No ☐

Have you ever had a venereal disease?

Yes ☐ No ☐

Do you get yeast infections regularly?

Yes ☐ No ☐

Have you ever been diagnosed with a Chlamydia infection?

Yes ☐ No ☐

Have you ever had pelvic inflammatory disease?

Yes ☐ No ☐

Were you treated for it?

Yes ☐ No ☐

How?

_____

Date of last Pap smear _____

Have you ever been diagnosed with uterine fibroids or polyps?

Yes ☐ No ☐

Have you ever been diagnosed with endometriosis?

Yes ☐ No ☐

Have you been diagnosed with pelvic adhesions?

Yes ☐ No ☐

Have you been diagnosed with any pelvic abnormalities?

Yes ☐ No ☐

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Have you taken any medications for gynecological conditions other than contraceptives?

Medication **How long**

_____

_____

_____

_____

_____

Have your cycles changed since they began?

Yes ☐ No ☐

How?

_____

Do you ovulate on your own?

Yes ☐ No ☐

On what day of your cycle? _____

Do your breasts get tender at/during ovulation?

Yes ☐ No ☐

Do you get premenstrual low back pain?

Yes ☐ No ☐

Do you have chronic vaginal discharge?

Yes ☐ No ☐

Do you have any sores on your genitalia?

Yes ☐ No ☐

Have you had fertility treatments?

Yes ☐ No ☐

If yes, when

where?_____

_____

What types?

_____

Have you taken medication to help you ovulate?

Yes ☐ No ☐

Have your fallopian tubes been evaluated medically?

Yes ☐ No ☐

What were the results?

_____

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Have you had any tubal operations?

Yes ☐ No ☐

Have you had any hormone laboratory tests performed?

Yes ☐ No ☐

What were the results?

_____

_____

Do you have a single partner with whom you have been trying to conceive?

Yes ☐ No ☐

How long have you been married or living together? _____

Is your partner supportive of your wish to conceive?

Yes ☐ No ☐

Have you taken oral contraceptives?

Yes ☐ No ☐

When? _____ How long? _____

Have you ever had an IUD?

Yes ☐ No ☐

When? _____ How long? _____

Have you ever taken DepoProvera?

Yes ☐ No ☐

When? _____ How long? _____

How long have you been trying to conceive?

_____

Have you had a diagnosis relating to infertility?

_____

_____

Do your bowel movements become loose at the beginning of your period?

Yes ☐ No ☐

How is your sexual energy?

Low ☐ Normal ☐ High ☐

Do you douche regularly?

Yes ☐ No ☐

With what?

_____

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Do you use vaginal lubricants?

Yes ☐ No ☐

Are you more than 20% over your ideal body weight?

Yes ☐ No ☐

Do you have a stressful occupation?

Yes ☐ No ☐

Do you exercise regularly?

Yes ☐ No ☐

Do you have excessive facial hair?

Yes ☐ No ☐

Do you have excessively oily skin?

Yes ☐ No ☐

Have you experienced excessive loss of head hair?

Yes ☐ No ☐

Have you noticed discharge from your nipples?

Yes ☐ No ☐

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you?

Yes ☐ No ☐

Have you been exposed to any known environmental toxins or hormones?

Yes ☐ No ☐

Are you presently taking steroids?

Yes ☐ No ☐

Semen Analysis:

Count:_____

Morphology:_____

Motility:_____

Progression:_____

PH:_____

Fragmentation:_____

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____
BIRTHDATE _____
HEALTH INSURANCE ID (or Social Security#) _____

I understand that as part of my healthcare, or my legal dependent's healthcare, this Organization originates and maintains health records describing health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:
• A basis for planning care and treatment.
• A means of communication among the many healthcare professionals who contribute to care.
• A source of information for applying diagnostic and medical information to a bill.
• A means by which a third-party payer can verify that services billed were actually provided.
• A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:
• To object to the use of health information for directory purposes.
• To request restrictions as to how this health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
• To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

_____

_____

Patient/Legal Representative signature: _____

Witness signature: _____

Date: _____

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MEDICAL APPOINTMENT CANCELLATION POLICY

Dear Patient,

Thank you for trusting your medical care to Sharareh Daghighi Acupuncture/Acuwellness Center. We strive to render excellent medical care to you, your family and all of our patients. In order to be consistent with this philosophy, Acuwellness Center uses an appointment system that sets aside ample time for a patient dependent on the patient's current needs. If you do not show up for your appointment, or notify us of your inability to keep your appointment by phone at least 24 hours in advance, the time that has been allotted for your visit cannot be used to treat another patient and is time lost to our office. With that in mind and in order to keep costs as low as possible, a Medical Appointment Cancellation Policy has been put into place.

Our policy is as follows:

1. We request that you please give our office a 24-hour notice in the event that you need to reschedule your appointment. This will make the appointment time available to someone else. Our scheduling number is 818-642-3512.
2. If you miss an appointment and do not contact us with at least 24 hours prior notice we will consider this to be a missed appointment and a $50.00 fee will be assessed to you.
3. If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length.

If you have any questions regarding this policy, please contact Sherry Daghighi at the above address or phone number and he will be glad to clarify any questions you may have. We thank you for your patronage.

I have read and understand the Medical Appointment Cancellation Policy and agree to be bound by its terms.

_____

Signature (Parent / Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date

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By signing this authorization, I authorize you to use and/or disclose certain protected health information (PHI) about me to:

Sharareh Daghighi, DAOM, L.Ac.
16260 Ventura Blvd, Suite LL16
Encino, CA 91436
Phone: 818-642-3512
Fax: 818-789-8890

Dear Dr, _____

I authorize you to release a copy of the medical records of:

Patient name: _____ Date of birth: _____

Social Security #: _____ covering the period of _____to _____

Please fax the records to above address.

The specific information requested is the office visits, labs, x-ray, surgeries, op reports, etc. The purpose(s) is/are provided so that I can make informed decision whether to allow release of the information.

The authorization will expire on _____

I release you from all legal responsibility or liability that may arise from this authorization.

Please release my medical records, including:

All of my medical records (excluding HIV testing)

My entire medical records (Including HIV testing)

Please exclude the followings: _____

Patient's signature: _____ Date: _____

Patient's name: _____