Workers Comp. Claim Number:

**All Wellness Now**

720 Magnolia Ave, Ste B3 Corona CA, 92879 T:951-371-8888

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender M/F

First Name, Last Name

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zipcode\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Insurance :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_Relationship to you\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Currently working: Y/N SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Workers Comp Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is Injury work related? Yes\_\_\_\_ No\_\_\_\_ Adjuster Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Adjuster phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WC Physician Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WC Physician Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your current health problem(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What treatment have you received for the above condition(s)\_\_ Surgery \_\_\_ Medications \_\_\_Physical Therapy \_\_\_\_Injections\_\_\_\_

Chiropractic\_\_\_ Therapeutic Massage: \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your progress: \_\_\_\_Worse \_\_\_ No Change\_\_\_\_0-25%Better\_\_\_26-50%Better \_\_\_51-75%Better\_\_\_76-100% better

|  |
| --- |
| Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper back, Low Back, Tailbone, Hip, Thigh  Knee, Ankle, Foot, Chest, Abdomen, Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  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 activities |

How often are your symptoms present? 0-25% 26-50% 51-75% 76-100%

Describe your current health overall Excellent Very good Good Fair Poor

What are your goals for your acupuncture treatments? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How will you track your progress towards your goals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all the following that apply to you and list any medication(s) you are taking:

Alcohol/ Drug dependence Frequent Urination Weight gain/ loss

Abnormal menstruation Headache Sinusitis

Allergies Heart Attack (date\_\_\_\_\_\_\_\_\_) Stoke( date\_\_\_\_\_\_\_\_\_\_\_\_\_)

Angina Heartburn Indigestion Tobacco Use- Type\_\_\_\_\_\_\_\_\_\_

Arthritis/ High blood pressure Frequency\_\_\_\_\_\_\_\_\_/Day

Rheumatoid Arthritis Hospitalizations (date\_\_\_\_\_\_\_\_ Thyroid Disease

Artificial Joints (list date and reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and joint) Surgeries (list date and type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma Kidney disease Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood Disorder Liver problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast Lumps Osteoporosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer/tumor (type and date) Pacemaker

Convulsions/Seizures Palpitation/ Arrhythmia If a family has had any of the

Diabetes Peptic Ulcer following, please mark the

Diarrhea/ Constipation Pregnant # weeks\_\_\_\_\_\_\_\_\_\_\_\_ appropriate box and explain

Excessive Thirst If pregnant, are you under a medical doctor care? Cancer Fatigue Prostate Problems Heart Disease Fever Hypertension Lupus

**Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I certify the above information is complete and accurate to the best of my knowledge. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services. I agree to notify this practitioner immediately whenever I have changes in my health condition or health condition or health plan coverage. I understand that my practitioner of acupuncture services may need to contact my Primary Care Physician or treating physician if my condition needs to be co-managed. Therefore, I give authorization to my practitioner of acupuncture services to contact my medical doctor if necessary.

Patient or Guardian signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_