



Advanced Pain Clinic, Inc.
7151 Lincoln Ave., Suite K
Buena Park, CA 90620
Tel. (714) 952-1080 – Fax (714) 952-1660

EMAIL: _____

NAME _____ Họ và tên (Nombre)	SOCIAL SECURITY # _____ Số an ninh xã hội (Segundo Social #)	SEX: _____ F _____ M Phái nam, nữ (Sexo)	
BIRTHDATE _____ Ngày sinh (Fecha de Nacimiento)	DRIVER LIC. # _____ Licencia de Hangjar	EXPIRES _____ Expiracion	
ADDRESS _____ Địa chỉ (Direccion)	CITY _____ Thành phố (Ciudad)	ST _____ Calle	ZIP _____ Z. Postal
OCCUPATION _____ Nghề nghiệp (Occupacion)	HOME PHONE: _____ Điện thoại ở nhà (Tele-Casa)	CELL PHONE: _____	
EMPLOYER _____ Chủ/Sở làm (Trabajo)	WORK PHONE: _____ Điện thoại sở làm (Tele-Trabajo)		
ADDRESS _____ Địa chỉ (Direccion)	CITY _____ Thành phố (Ciudad)	ST _____ Calle	ZIP _____ Z. Postal
MARITAL STATUS: (Check one) _____ Tình trạng gia đình (Estado Civil)	SINGLE _____ Độc thân (Soltero)	MARRIED _____ Có gia đình (Casado)	OTHER _____ Trường hợp khác (Oteo)
SPOUSE'S NAME _____ Tên chồng hoặc vợ (Nombre del Conyugue)	OCCUPATION _____ Nghề nghiệp (Occupacion)		
INSURANCE COMPANY _____ Công ty bảo hiểm (Co. de Aseguranza)	PHONE _____ Điện thoại (Tele)		
ADDRESS _____ Địa chỉ (Direccion)			
POLICYHOLDER _____ Người có bảo hiểm (Asegurado)	POLICY NO. _____ Khế ước số (Poliam #)	GROUP NO. _____ Nhóm số (Grupo #)	
SOCIAL SECURITY # _____ Số an ninh xã hội (Segundo Social #)	MEDICARE NO. _____ Phiếu Mẽ-ti-keo so (Medicare #)		
ACCIDENT _____ Tai nạn (Accidente)	ILLNESS _____ Bệnh (Enfermedad)	INJURY ON DUTY _____ Bị thương ở sở (Accidente de trabajo)	DATE _____ Ngày (Fecha)
NEAREST RELATIVE _____ Bà con gần nhất (Pariente sercano)	ADDRESS _____ Địa chỉ (Direccion)	PHONE _____ Điện thoại (Tele)	
REFERRED BY _____ Cố quan, người giới thiệu tới (Recomedado por)	ADDRESS _____ Địa chỉ (Direccion)	PHONE _____ Điện thoại (Tele)	

HAS ANY MEMBER OF YOUR IMMEDIATED FAMILY BEEN TREATED BY THIS OFFICE? YES NO
Trong gia đình có ai đến khám bệnh tại Phòng Mạch này chưa? (Algun familiar ha sido tratado aqui?)

I hereby authorize Dr. KHANH LAM to furnish information to insurance carriers concerning this illness and I hereby irrevocably assign to the doctor all payments for medical services render.
(Autoriso a los Dr. KHANH LAM, L.Ac. Ha par informacion a las aseguranas conserniente a my enfermedad. I assigno el pago para mis servicios medicos a ellos.)

SIGNATURE OF PATIENT (OR PARENT, IF MINOR)
Chủ ký của bệnh nhân (hoặc người chịu trách nhiệm)
Firma o Firma del Tutor

DATE
Ngày, tháng, năm
Fecha

the following symptom which you now or have had previously
 những triệu chứng đã hoặc đang xảy ra (Marqua sus Sintomas)

General - Tổng quát	Freq Occ		Muscle & Joint - Bắp thịt & khớp	Freq Occ	
	Thuong xuyên	Đôi lúc			
Allergy - dị ứng - Alergias	<input type="checkbox"/>	<input type="checkbox"/>	♦ Arthritis - Tê thấp	<input type="checkbox"/>	<input type="checkbox"/>
Convulsion - Lấn phong - Convulsion	<input type="checkbox"/>	<input type="checkbox"/>	♦ Foot Trouble - Đau chân - Problema pies	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness - Chóng mặt - Mareos	<input type="checkbox"/>	<input type="checkbox"/>	♦ Low Back Pain - Đau lưng - Rumbago	<input type="checkbox"/>	<input type="checkbox"/>
Fainting - Chóng váng - Desmayos	<input type="checkbox"/>	<input type="checkbox"/>			
Headache - Nhức đầu - Dolor de Cabeza	<input type="checkbox"/>	<input type="checkbox"/>	Eyes, Ears, Nose, Throat (Tai, mũi, họng)		
Neuralgia - Nhức gân - Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	♦ Asthma - Suyễn	<input type="checkbox"/>	<input type="checkbox"/>
Numbness - Tê, cứng - Entumecimiento	<input type="checkbox"/>	<input type="checkbox"/>	♦ Colds - Cảm, cúm - Catarro	<input type="checkbox"/>	<input type="checkbox"/>
Colon Trouble - Đau ruột - Problema del colon	<input type="checkbox"/>	<input type="checkbox"/>	♦ Deafness - Điếc - Sordera	<input type="checkbox"/>	<input type="checkbox"/>
Constipation - Táo bón - Constipacion	<input type="checkbox"/>	<input type="checkbox"/>			
Diarrhea - Ỉa chảy - Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Cardio-Vascular - Tim-Máu		
Difficult Digestion - Khó tiêu - Mala Digestion	<input type="checkbox"/>	<input type="checkbox"/>	♦ Hardening of arteries - Cứng động mạch	<input type="checkbox"/>	<input type="checkbox"/>
Liver Trouble - Đau gan - Problema de Hígado	<input type="checkbox"/>	<input type="checkbox"/>	Arterias endurecidas		
Pain over stomach - Đau bao tử	<input type="checkbox"/>	<input type="checkbox"/>	♦ High blood pressure - Áp huyết cao - Presion Alta	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids - Đau trĩ - Hemorrhoides	<input type="checkbox"/>	<input type="checkbox"/>	♦ Low blood pressure - Áp huyết thấp - Presion Baja	<input type="checkbox"/>	<input type="checkbox"/>
Neck pain or stiffness - Đau cổ - Cuello Duro	<input type="checkbox"/>	<input type="checkbox"/>	♦ Pain over heart - Đau tim - Dolor de corason	<input type="checkbox"/>	<input type="checkbox"/>
Pain between shoulders - Đau giữa hai vai - Dolorentre los hombros	<input type="checkbox"/>	<input type="checkbox"/>	♦ Rapid heart beat - Tim đập mau - Palpitacion rapid	<input type="checkbox"/>	<input type="checkbox"/>
Pain or numbness in: - Đau, tê: - Dolor, Entumecimiento en:			♦ Slow heart beat - Tim đập chậm - Palpitacion lenta	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder - vai - hombros	<input type="checkbox"/>	<input type="checkbox"/>	♦ Swelling of ankles - Sưng mắt cá chân	<input type="checkbox"/>	<input type="checkbox"/>
Arms - cánh tay - brajos	<input type="checkbox"/>	<input type="checkbox"/>	Incrason du tobillos		
Elbows - khuỷu tay - codos	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory - Hô hấp		
Hands - bàn tay - manos	<input type="checkbox"/>	<input type="checkbox"/>	♦ Chest pain - Đau ngực - Dolor de pecho	<input type="checkbox"/>	<input type="checkbox"/>
Hips - hông - caderas	<input type="checkbox"/>	<input type="checkbox"/>	♦ Chronic cough - Ho kinh niên - Tos cronick	<input type="checkbox"/>	<input type="checkbox"/>
Legs - chân - piernas	<input type="checkbox"/>	<input type="checkbox"/>	♦ Difficulty breathing - Khó thở - Dificult al respirar	<input type="checkbox"/>	<input type="checkbox"/>
Feet - bàn chân - pies	<input type="checkbox"/>	<input type="checkbox"/>	♦ Spitting up blood - Khạc ra máu - Escupe sangre	<input type="checkbox"/>	<input type="checkbox"/>
Sciatica - nhức gân ở chân - siatica	<input type="checkbox"/>	<input type="checkbox"/>	♦ Spitting up phlegun - khạc ra đờm - Escupe flema	<input type="checkbox"/>	<input type="checkbox"/>
			♦ Wheezing - Khò khè - Respiracion dificultosa	<input type="checkbox"/>	<input type="checkbox"/>
Genio Urinary - Đường tiêu			For Women - Quý bà - Para Mujeres		
Frequent urination - Đái lắt nhắt - Urinacion frec.	<input type="checkbox"/>	<input type="checkbox"/>	♦ Congested breast - Ngực căng - Conjestion de seno	<input type="checkbox"/>	<input type="checkbox"/>
Painful urination - Đau khi đái - Urinacion	<input type="checkbox"/>	<input type="checkbox"/>	♦ Cramps or backache - Vọp bẻ, đau lưng	<input type="checkbox"/>	<input type="checkbox"/>
Pus in urine - Đái ra mủ - Pus en la orina	<input type="checkbox"/>	<input type="checkbox"/>	Dolores de espalda		
Blood in urine - Đái ra máu - Sangre en orina	<input type="checkbox"/>	<input type="checkbox"/>	♦ Excessive menstrual - Có kinh nguyệt quá lâu	<input type="checkbox"/>	<input type="checkbox"/>
Dripping in urination - Đái sót - Coteos de oria	<input type="checkbox"/>	<input type="checkbox"/>	Mucha menstrual		
Earache - Đau tai - Dolor de oido	<input type="checkbox"/>	<input type="checkbox"/>	♦ Irregular cycle - kinh nguyệt không đều	<input type="checkbox"/>	<input type="checkbox"/>
Ear noises - Ù tai - Ruido en el oido	<input type="checkbox"/>	<input type="checkbox"/>	Cicle irregular		
Eye pain - Đau mắt - Dolor de ojos	<input type="checkbox"/>	<input type="checkbox"/>	♦ Lumps in breast - Bướu ở vú - Bolas en los senos	<input type="checkbox"/>	<input type="checkbox"/>
Nasal ostruction - Nghẹt mũi - Obstruccion nasal	<input type="checkbox"/>	<input type="checkbox"/>	♦ Painful menstration - Đau khi có kinh nguyệt	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleed - Chảy máu mũi - Sangra de nariz	<input type="checkbox"/>	<input type="checkbox"/>	Menstruacion con dolor		
Sinus infection - Viêm mũi - Infection de sinuses	<input type="checkbox"/>	<input type="checkbox"/>	♦ Vaginal discharge - Huyết đỏ	<input type="checkbox"/>	<input type="checkbox"/>
			Desecho vaginal anormal		
Skin - Da - Piel					
Dryness - Khô - Seca	<input type="checkbox"/>	<input type="checkbox"/>			
Skin Eruption - Sâu lở - Erupciones	<input type="checkbox"/>	<input type="checkbox"/>			
Varicose vein - Venas varicosas	<input type="checkbox"/>	<input type="checkbox"/>			

PREVIOUS HISTORY

Previous Injuries - Thương tích xảy ra từ trước - Accidente Previos _____

Previous Back Pain - Đau lưng lần trước - Previos dolores de esparoa _____

Diseases - Đau yếu khác - Enfermedades _____

Operation - Giải phẫu - Operaciones _____

Medication - Thuốc đang uống - Medicinal _____

Other Physicians - Bác sĩ khác - Otros doctoras _____

Other abnormalities - Những triệu chứng không bình thường - Otras Anormalidades _____

Information taken by - Hồ sơ được ghi bởi - Informacin esecita por _____ Date _____

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed acupuncturist and/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with or serving as a back-up for the treating acupuncturist named below, including those working at this office/clinic or any other office or clinic.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-na (Chinese massage), Chinese or Western herbal medicine, and nutritional counseling.

I have had the opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunction of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infections and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastro-intestinal upset or allergic reactions to the herbs I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:

PATIENT'S NAME _____
(PLEASE PRINT)

PATIENT'S SIGNATURE _____

DATE SIGNED _____

ARE YOU PREGNANT? YES NO

ADVANCED PAIN CLINIC, INC.
7151 LINCOLN AVE., SUITE K
NAME OF CLINIC/OFFICE _____ BUENA PARK, CA. 90620

NAME OF TREATING ACUPUNCTURIST (S) _____

To be completed by the patient's representative,
if necessary, e.g., if the patient is a minor or is
physically or legally incapacitated:

NAME OF PATIENT _____
(PLEASE PRINT)

PATIENT'S REPRESENTATIVE _____
(PLEASE PRINT)

RELATIONSHIP OR AUTHORITY OF PATIENT _____

WITNESS _____