nalini chilkov L.Ac., O.M.D.
DOCTOR OF ORIENTAL MEDICINE

CONFIDENTIAL

Welcome! Below you will find detailed information regarding your New Patient Visit.

PLEASE DOWNLOAD AND COMPLETE THE NEW PATIENT FORMS BEFORE YOUR VISIT

Please click on this link or copy and paste it into your browser

http://www.nalinichilkov.com/ourpractice_forms.html

Driving and parking information is available on our website at
http://www.nalinichilkov.com/contact_hours.html

If you need to reschedule your appointment we appreciate 48 hours advance notice

What to bring to the first visit:

1. **Completed New Patient Forms**
2. **Supplements and Medications**: A list of all of your current supplements and medications AND also bring the actual bottles of your herbs and supplements
3. **Records**: Any pertinent medical records. Medical records can only be released with your authorization. A medical records release form is included for your use. You are responsible for obtaining previous medical records from other physicians or health care providers. Please contact your physician or other health care provider to obtain these records.

Bring your records with you to your first visit OR have them sent

- By Fax: 424-280-3014
- By Email: patients@healthtools.com
- By Mail: 2632 Wilshire Blvd. Suite 496, Santa Monica, CA 90403

If you do not have relevant records for review at your first appointment Dr. Chilkov will review them at a later date.

Time Dr. Chilkov will spend approximately 90 minutes with you going over your health and lifestyle history in detail and discussing all of your concerns.

The first visit may or may not include a treatment, depending upon the complexity of your history and the nature of your concern. Of course, if you are in pain or suffering from an acute condition, an exam and treatment will be included. If your history is complex the examination and treatment will be done on your second visit.

We accept cash, checks, Visa, Mastercard and American Express for payment.

If you have any questions or concerns please do not hesitate to contact us

at 310-453-5700 or patients@healthtools.com

To learn more about Integrative Cancer Care visit Dr. Nalini's Blog

To join our private exclusive patient email list PLEASE CLICK HERE

We look forward to being of service to you!

PRINT SAVE

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RESET EMAIL

TODAY'S DATE_____

PATIENT BILLING AND CONTACT INFORMATION

Name:_____ Social Security Number:_____

Parent's Name(s) *(if patient is a child)*_____

Address:_____ City:_____State:_____ZipCode:_____

Birthdate:_____Age:_____Sex:_____Marital Status:_____

Home Phone:_____Fax:_____:_____

Cell Phone:_____Email Address:_____

Occupation:_____Employer:_____

Address:_____ City:_____State:_____ZipCode:_____

Work Phone:_____Work Fax:_____Employer's Phone:_____

Spouse's Employer:_____Address:_____

Who is responsible for this account?_____Where should bills be sent?_____

Name:_____Address:_____

City:_____State:_____ZipCode:_____Phone:_____

If address is same as patient's, check here: ☐

Referred By:_____

In case of Emergency contact: Name:_____Phone:_____Relationship:_____

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OFFICE POLICIES AND FINANCIAL AGREEMENT

The fees charged in this office are comparable to those charged by other specialists with similar qualifications in this area. The fees for office services, supplements and supports are payable in full at the time of your visit unless other arrangements have been made.

Phone and email consultations (longer than 5-10 minutes) are charged on an hourly rate.

If it is necessary for you to cancel or reschedule an appointment we require a **FULL 24 HOURS NOTICE** to change your appointment without charge. Any *appointments canceled or rescheduled without 24 hours notice* will be charged for a *full office visit*. Please realize we have reserved this time for you and that another person in need of care will be able to have time with the doctor when 24 hours notice is given. If you are more than 20 minutes late for your appointment, we may not be able to accommodate you.

Please understand that we have no payment agreements with your insurance company. Insurance benefits are a matter between you and your insurance company. We will be happy to supply you with any information you may need to assist you in procuring payment of your medical claims. Submission of medical insurance claims is the responsibility of the insured.

If you are a patient who has had a non-work related accident, automobile or other injury, it is your responsibility to provide us with the name and address of both the responsible insurance companies and that of your attorney.

We reserve the right to make a finance charge at an interest rate of 1.5% per month for every month that your account remains overdue after 30 days.

I have read, understand, and agree to the above policies.

Name (Print)_____

(If patient is a minor) Name of child for whom I am parent or legal guardian_____

_____ _____

Signature Date

INFORMED CONSENT

Nalini Chilkov, L.Ac., O.M.D.. is a Licensed Acupuncturist and Doctor of Oriental Medicine. Dr. Chilkov is not a medical doctor. She does not claim to diagnose, treat, cure or prevent any medical conditions or pathologies, nor prescribe medicine, nor in any way represent herself as so doing. The services of a Doctor of Oriental Medicine cannot replace those of a licensed physician. For any medical condition, you are advised to seek care from an appropriate medical practitioner. Whether you choose to engage a medical practitioner or not to assist you in your care is your right and Dr. Chilkov assumes no responsibility for your decision in this matter.

I, the undersigned, assume all responsibility for decisions I make regarding my health, recognizing that (a) no claims are made that acupuncture, herbal, nutritional, or dietary recommendations can treat or cure any medical condition, (b) all recommendations are given for informational purposes only, (c) there is no implied or stated guarantee of success or effectiveness of any specific acupuncture, dietary, nutritional, or herbal recommendations, (d) I am free to act upon or disregard the recommendations of Nalini Chilkov, L.Ac., O.M.D as I so choose. I hereby release Dr. Nalini Chilkov and the Office of Nalini Chilkov, O.M.D from all responsibility for my actions and any consequences thereof in the present time and in the future with no constraints. I hereby affirm that I consent and agree to the above statements of my own free will and request to engage in the services offered by Nalini Chilkov, L.Ac., O.M.D. and participate in a professional relationship with her pursuant to the statements herein.

Name (Print)_____

(If patient is a minor) Name of child for whom I am parent or legal guardian_____

_____ _____

Signature Date

CHILD/MINOR REGISTRATION

PATIENT INFORMATION

Name of Minor/Child:_____

Birthdate:_____ Social Security Number:_____ Age_____ Sex_____

Nickname:_____ Hobbies:_____

Home Address:_____ City:_____ State:_____ ZipCode:_____

Home Address:_____ City:_____ State:_____ ZipCode:_____

Mailing Address:_____ City:_____ State:_____ ZipCode:_____

Person Financially responsible for this account?_____ Relationship_____

Father's Name_____ Email_____ Cell:_____

Mother's Name_____ Email_____ Cell:_____

Home Phone:_____ Work Phone:_____ Primary Email:_____

Whom May we thank for Referring you:_____

EMERGENCY CONTACT (IN THE EVENT OF AN EMERGENCY, WHOM SHOULD BE CONTACT?)

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

FAMILY HISTORY

FAMILY HISTORY	Child	Mother	Father	Brother	Sister	Grand parents	Comments
Arthritis	Y	Y	Y	Y	Y	Y	
Asthma/Hay Fever	Y	Y	Y	Y	Y	Y	
Cancer	Y	Y	Y	Y	Y	Y	
Drug/Alcohol Dependency	Y	Y	Y	Y	Y	Y	
Convulsions/Epilepsy	Y	Y	Y	Y	Y	Y	
Diabetes	Y	Y	Y	Y	Y	Y	
Heart Disease	Y	Y	Y	Y	Y	Y	
High Blood Pressure	Y	Y	Y	Y	Y	Y	
Kidney Disease	Y	Y	Y	Y	Y	Y	
Migraine	Y	Y	Y	Y	Y	Y	
Mental/Emotional Disorders	Y	Y	Y	Y	Y	Y	
Tuberculosis	Y	Y	Y	Y	Y	Y	
Bleeding Disorders	Y	Y	Y	Y	Y	Y	
Weight Problems	Y	Y	Y	Y	Y	Y	
Other:_____	Y	Y	Y	Y	Y	Y	

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BIRTH HISTORY

Hospital:_____ Obstetrician:_____

Type of Delivery: ☐ Vaginal ☐ C-Section ☐ Forceps ☐ Medicated ☐ Natural ☐ Other:_____

Complications during Pregnancy or Labor & Delivery:_____

Normal Birth Weight?_____ Problems immediately after birth?_____

	Cooed/Laughed	Sat Up	Held Held Up	Walked	Toiled Trained
Age at which child first					

Breastfeeding? ☐ Y ☐ N If yes, for how long/any problems?_____

Formula_____ Milk/Dairy Base_____ Soy Base_____

CHILD'S HEALTH HISTORY

Name of Pediatrician:_____ Phone:_____

Date last seen by Pediatrician:_____ For:_____ Results:_____

Current Prescription Medications:_____

Number of times child has taken antibiotics?_____ For:_____ Results:_____

Current Vitamins/Herbs/Homeopathic Medicines:_____

Known Allergies: ☐ Dust ☐ Pollens/Grasses ☐ Foods(*list)*_____

☐ Other_____

Has your child ever been hospitalized? ☐ Yes ☐ No If yes, why?_____

CHILD'S MEDICAL HISTORY (*CHECK ALL THAT APPLY*)

☐ AIDS/HIV	☐ Anemia	☐ Asthma	☐ Bed Wetting
☐ Birth Defects	☐ Bladder Problems	☐ Bleeding problems	☐ Bronchitis/Frequent Coughing
☐ Cancer	☐ Cerebral Palsy	☐ Chicken Pox	☐ Constipation/Diarrhea
☐ Convulsions	☐ Diabetes	☐ Drug/Alcohol Use	☐ Ear Infections
☐ Epilepsy	☐ Fainting	☐ Hearing Problems	☐ Heart Problems
☐ Hepatitis	☐ Kidney Disease	☐ Lead Poisoning	☐ Liver Disease
☐ Measles	☐ Mononucleosis	☐ Mumps	☐ Pneumonia
☐ Rheumatic Fever	☐ Sinus Problems	☐ Skin Rashes	☐ Sleep Problems
☐ Speech Problems	☐ Thyroid Disease	☐ Tuberculosis	☐ Urinary Disease
☐ Vision problems	☐ Weight Problems	☐ Worms/Parasites	

IMMUNIZATIONS (*CHECK ALL THAT APPLY*)

☐ Diptheria/Tetanus	☐ DPT Booster	☐ DPT series
☐ Hepatitis	☐ HPV	☐ Measels
☐ Mumps Chicken Pox	☐ Overseas Immunizations	☐ Polio Booster
☐ Polio series (oral)	☐ Polio series(Injection)	☐ Rubella

☐ Tuberculin Test Result(+)_____ (-)_____

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DIET

What does child eat for:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

On a Special Diet ☐ Y ☐ N If yes, why, and please describe:

Cravings (C) and Aversions (A)

____ Salty	____ Sour	____ Sweet	____ Spicy	____ Bitter
____ Bread/Pasta	____ Oily/Fatty	____ Eggs	____ Milk/Dairy	
____ Chocolate	____ Warm Foods	____ Iced/Cold Foods	____ Other: _____	

Eating Issues

☐ Weight Fluctuations	☐ Overeating	☐ Bulimia	☐ Use of diet pills/appetite suppressants
☐ Food Binges	☐ Anorexia	☐ Vomit after eating	
☐ Frequent Dieting	☐ Dissatisfied with current body weight	☐ Satisfied with current body weight	

MISCELLANEOUS

Position of Sleep:_____Likes to be covered?_____Throws off blankets_____

Prefers to be: ☐Inside ☐Outside ☐Bundled up ☐Clothes off

Better**(B)**/Worse**(W)** ____Spring ____Summer ____Fall ____Winter ____Dampness/Humidity ____Dryness ____Sea Shore

Any time of day (*be specific*) when your child is better or worse. Describe:

☐affectionate	☐angry	☐bold	☐cannot be easily comforted	☐difficult to please
☐fearful	☐happy	☐irritable	☐Likes fresh air/window open	☐likes to be held
☐outgoing	☐sad	☐Sensitive to drafts/wind	☐serious	☐timid
☐violent				

Does your child get along well/play with other children?_____

Any learning or attention problems?_____

Social problems?_____

Emotional problems?_____

Can the child play by himself/herself?_____

Any discipline problems?_____

Any major changes or stresses in the child's life recently? ☐ Y ☐ N If yes, describe:

	Mother	Father	Nanny	Daycare	School	Other_____
How much time does the child have each day with						

Sports/Exercise/Hobbies/Interests/Talents

Brothers and Sisters? (*Please list names/ages)*

Name	Age	Name	Age	Name	Age

Parents ☐ separated or ☐ divorced? ☐ Step parents? ☐ Blended Families?

Living situation of child?_____

Please describe anything else that is particular to your child.

PLEASE LIST, IN ORDER OF IMPORTANCE, WHAT IS OF MOST CONCERN TO YOU WITH RESPECT TO YOUR CHILD'S WELL-BEING?
Primary Reasons for Consultation?

1.
2.
3.
4.
5.
6.
7.
8.

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