PERSONAL INFORMATION

LAST NAME ______________________________

FIRST NAME ______________________________

ADDRESS ______________________________

CITY ______________________________

STATE ____________ ZIP ______________

REFERRED BY ______________________________

SEX ☐ Female ☐ Male

MARITAL STATUS ☐ Single ☐ Married

☐ Divorced ☐ Widowed ☐ Separated

NAME OF SPOUSE ______________________________

HOME # ______________________________

WORK # ______________________________

CELL # ______________________________

BEST # TO REACH YOU: ☐ HOME ☐ CELL ☐ WORK

SOCIAL SEC. # ________ - ________ - ________

BIRTHDATE____________AGE____________

EMPLOYER ______________________________

OCCUPATION______________________________

only if minor- NAME OF PARENTS

____

INSURANCE INFORMATION

PRIMARY PHYSICANS NAME______________________________

PRIMARY INS. COMPANY NAME______________________________

ADDRESS ______________________________ TEL.# ______________________________

POLICYHOLDER NAME ______________________ RELATIONSHIP TO PATIENT ______________

BIRTHDATE ______________________________ SOCIAL SEC.# ______________________

POLICY/ID # ______________________________ GROUP NAME/ NUMBER ________________

SECONDAY INS. COMPANY NAME ______________________________

ADDRESS ______________________________ TEL.# ______________________________

POLICYHOLDER NAME ______________________ RELATIONSHIP TO PATIENT ______________

BIRTHDATE ______________________________ SOCIAL SEC.# ______________________

POLICY/ID # ______________________________ GROUP NAME/ NUMBER ________________

GEORGE MARS, MD - 645 SIERRA ROSE #202 RENO, NV 89511 (775) 825-9990 - Fax (775) 827-1161

NAME________________________________ AGE ______DOB___________

HEALTH QUESTIONAIRE

Major complaint: ____

____

____

Past and current medical conditions: ____

____

____

Past surgeries: ____

____

Drug allergies: ____

____

List all current medications and supplements: ______________________________________

____

____

HISTORY OF PAST ILLNESS

Measles	☐ YES	☐ NO	Rheumatic fever or heart disease	☐ YES	☐ NO
Mumps	☐ YES	☐ NO	Tuberculosis	☐ YES	☐ NO
Chickenpox	☐ YES	☐ NO	Venereal disease	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO	Congenital abnormalities	☐ YES	☐ NO
Stroke	☐ YES	☐ NO	Other serious disease	☐ YES	☐ NO
Cancer	☐ YES	☐ NO	______________________		

Have you had any serious illness? ☐ YES ☐ NO

Have you ever been hospitalized or been under medical care for a prolonged condition? ☐ YES ☐ NO

If yes, for what reason? ____

Have you had any injuries, i.e. broken bones, concussions, etc? ______________________

____

FAMILY HISTORY

HEALTH:	Good	Poor	Deceased	Medical Problems	Cause of Death	Age
Yourself	____	____	_______			
Mother	____	____	_______			
Father	____	____	_______			
Brothers	____	____	_______			
Sisters	____	____	_______			
Children	____	____	_______			
Spouse	____	____	_______			

NAME________________________________ AGE ______DOB___________

SKIN

- Skin disease ☐ YES ☐ NO
- Jaundice ☐ YES ☐ NO
- Hives, eczema or rash ☐ YES ☐ NO
- Freq. infection or boils ☐ YES ☐ NO
- Abnormal pigmentation ☐ YES ☐ NO

HEAD, EYES, EARS, NOSE & THROAT

- Eye disease or injury ☐ YES ☐ NO
- Do you wear glasses? ☐ YES ☐ NO
- Double vision ☐ YES ☐ NO
- Headaches ☐ YES ☐ NO
- Glaucoma ☐ YES ☐ NO
- Itching eyes or nose ☐ YES ☐ NO
- Sneezing or runny nose ☐ YES ☐ NO
- Nose bleeds ☐ YES ☐ NO
- Chronic sinus trouble ☐ YES ☐ NO
- Ear disease ☐ YES ☐ NO
- Impaired hearing ☐ YES ☐ NO
- Dizziness or transient episodes of unconsciousness ☐ YES ☐ NO

NECK

- Stiffness ☐ YES ☐ NO
- Thyroid trouble ☐ YES ☐ NO
- Enlarged glands ☐ YES ☐ NO

NEURO-PSYCHIATRIC

- Ever had psychiatric care ☐ YES ☐ NO
- Ever seen a Psychiatrist ☐ YES ☐ NO
- Do you ever have, or have had,
- Fainting spells ☐ YES ☐ NO
- Paralysis ☐ YES ☐ NO

CARDIOVASCULAR

- Chest pain or angina pectoris ☐ YES ☐ NO
- Shortness of breath with walking or lying down ☐ YES ☐ NO
- Difficulty walking two blocks ☐ YES ☐ NO
- Heart troubles or Heart attacks ☐ YES ☐ NO
- High blood pressure ☐ YES ☐ NO
- Swelling of hands, feet, or ankles ☐ YES ☐ NO
- Awaking in the night smothering ☐ YES ☐ NO
- Heart murmur ☐ YES ☐ NO

GASTROINTESTINAL

- Peptic ulcer disease ☐ YES ☐ NO
- Vomiting blood or food ☐ YES ☐ NO
- Gallbladder disease ☐ YES ☐ NO
- Liver trouble ☐ YES ☐ NO
- Painful bowel movements ☐ YES ☐ NO
- Bleeding with bowel movements ☐ YES ☐ NO
- Black stool ☐ YES ☐ NO
- Hemorrhoids or piles ☐ YES ☐ NO
- Recent change in bowel habits ☐ YES ☐ NO
- Frequent diarrhea ☐ YES ☐ NO
- Heartburn or indigestion ☐ YES ☐ NO
- Cramps or pain in the abdomen ☐ YES ☐ NO
- Does food stick in throat ☐ YES ☐ NO

GENTOURINARY

- Loss of urine ☐ YES ☐ NO
- Frequent urination ☐ YES ☐ NO
- Nighttime urination ☐ YES ☐ NO
- Burning or painful urination ☐ YES ☐ NO
- Blood in urine ☐ YES ☐ NO
- Kidney trouble ☐ YES ☐ NO
- Kidney stones ☐ YES ☐ NO

GYNECOLOGICAL

- Age periods started ________________
- How long do periods last? ________________ days
- Number of pregnancies ________________
- Number of miscarriages ________________
- Date of last PAP smear and results________________
- Frequency of periods, every ________________ days
- Any pain with your periods ☐ YES ☐ NO
- Date of last mammogram ________________
- Date of first day of last period ________________

MUSCULOSKELETAL

- Varicose Veins ☐ YES ☐ NO
- Weakness of muscles or joints ☐ YES ☐ NO
- Any difficulty in walking ☐ YES ☐ NO
- Any pain in calves or buttocks ☐ YES ☐ NO

RESPIRATORY

- URI (cold) ☐ YES ☐ NO
- Spitting up blood ☐ YES ☐ NO
- Chronic freq. Cough ☐ YES ☐ NO
- Asthma or wheezing ☐ YES ☐ NO
- Difficulty breathing ☐ YES ☐ NO
- Any trouble with lungs ☐ YES ☐ NO
- Pleurisy or Pneumonia ☐ YES ☐ NO

HEMATOLOGIC

- Are you slow to heal after cuts ☐ YES ☐ NO
- Blood disease ☐ YES ☐ NO
- Anemia ☐ YES ☐ NO
- Phlebitis ☐ YES ☐ NO
- Ever have excessive bleeding after tooth surgery or extraction ☐ YES ☐ NO

ENDOCRINE

- Thyroid disease ☐ YES ☐ NO
- Hormone therapy ☐ YES ☐ NO
- Any change in hat or glove size ☐ YES ☐ NO
- Any change in hair growth ☐ YES ☐ NO
- Do you feel colder than before ☐ YES ☐ NO
- or skin become dryer ☐ YES ☐ NO

ALLERGIC

- Asthma ☐ YES ☐ NO
- Arthritis ☐ YES ☐ NO
- Nasal congestion ☐ YES ☐ NO
- Hives / Rashes ☐ YES ☐ NO
- Fatigue ☐ YES ☐ NO
- Sinusitis ☐ YES ☐ NO
- Headaches ☐ YES ☐ NO
- Hay fever ☐ YES ☐ NO
- Itchy eyes ☐ YES ☐ NO

ENERGETIC HISTORY

Mark your favorite:	**FLAVOR**	**SEASON**	**COLOR**
	Sour	Spring	Blue
	Bitter	Summer	Red
	Sweet	Indian Summer	Yellow
	Spicy	Fall/ Autumn	White
	Salty	Winter	Black

At what time of the day or night are your symptoms worse? ____________________________________ AM/ PM

Do you prefer to be inside or outside? ____

Do weather changes affect you? ☐ NO ☐ YES - How? ____

Do you sleep well? ☐ YES ☐ NO, elaborate ____

____

What is your energy level? worst 1 2 3 4 5 best

What makes your symptoms better? ____

____

or worse?____

What was the most significant medical or emotional occurrences in your life? ____

____

On a scale of 1- 10, what do you rate your present stress level? ____

What are the stressors in your life? ____

What is your greatest fear? ____

What makes you really happy? ____

NUTRITIONAL HISTORY

What do you eat and drink for:

Breakfast-____

Lunch- ____

Dinner- ____

Snacks-____

Do you have food allergies? ☐ NO ☐ YES- What are they? ____

Do you have any digestive problems? ____

Do you have regular bowel actions? ____

Do you feel sleepy or tired after eating? ____

Are you able to fast without symptoms? ____

SOCIAL HISTORY

What city do you live in? ____

Do you have children? ☐ NO ☐ YES- How many? ____

Do you have pets? ☐ NO ☐ YES- How many and what kind? ____

Do you smoke? ☐ NO ☐ YES- How much? ____

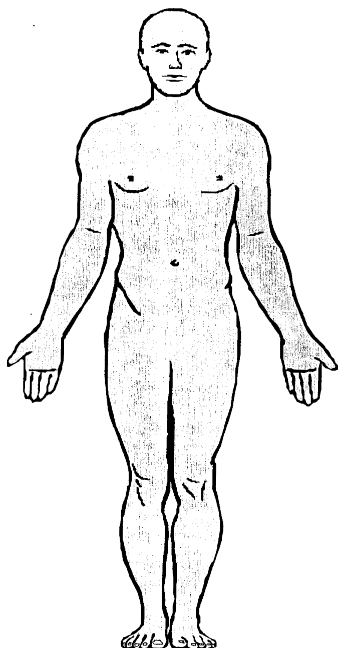
Do you drink alcohol? ☐ NO ☐ YES- How much? ____

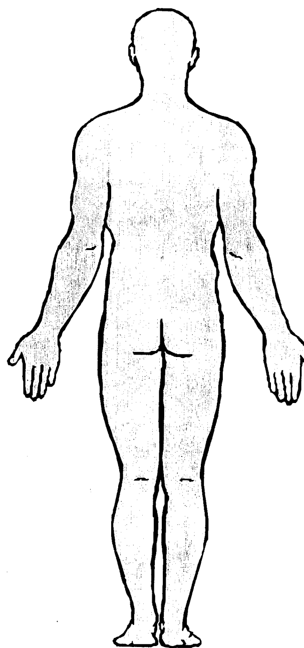
NAME_______________________________ AGE ______DOB___________

IF YOU ARE HAVING PHYSICAL PAIN, PLEASE COMPLETE THIS PAGE

PAIN DIAGRAM

aa: ACHING pp: PINS & NEEDLES nn: NUMBNESS ss: STABBING bb: BURNING





What do the following activities do to your pain?

	Relieves	Worsens	No Change
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Bending forward	☐	☐	☐
Bending backwards	☐	☐	☐
Side Bending Twisting	☐	☐	☐
Walking Upstairs	☐	☐	☐
Coughing	☐	☐	☐
Sneezing	☐	☐	☐

How is your pain during the course of the day? On a scale of 0 (no pain) – 10 (unbearable).

Morning ______________
Afternoon ______________
Evening ______________
Night ______________

How bad was your pain when you originally started? ___________________________
What is your pain level right now? ___________________________
Who first treated you? ___________________________
Medication used? ___________________________
How many doctors have you seen? ___________________________
Did the treatment work? ___________________________
Have you received physical therapy? ___________________________
If yes, how many times a week, for how many weeks? ___________________________

PATIENT CONSENT FORM AND OFFICE POLICIES

I, ________________________________ authorize George Mars, MD to perform the following procedures:

☐ **ACUPUNCTURE**

I authorize Dr. George Mars to perform acupuncture treatment. I have informed the Doctor of all the medications that I am currently taking, including birth control, blood thinners, vitamins, herbs, and all other prescription and over-the-counter medications. I have been informed that the side effects of **acupuncture** may include localized pain infection, bleeding at the site of insertion, bruising, needle shock (a faint feeling or actual fainting), and possible collapsed lung. I have also been informed I may experience a calming effect or fatigue. I have been informed the Doctor has given a 24 hour restriction, after acupuncture as follows; no heavy meals like buffet, NO ALCOHOL, no hot or cold beverages (no extreme temperatures, not excessive amounts), or no strenuous activity (including vigorous exercise and sexual activity). I understand the explanation above is only a precaution and awareness.

I have been informed that for treatment of chronic pain problems, it may require up to 6 treatments before any effect is experienced and that a course of 6 to 10 treatments is generally required for maximum effect. I understand that no guarantee has been made that the procedure will improve my condition, and that the procedure may make my condition worse.

☐ **EMG/ NCS (ELECTROMYOGRAPHY)**

I authorize Dr. George Mars to perform EMG. I have informed the Doctor of any blood thinning medication I am taking and/or having a pacemaker or have hemophilia. I have been informed that the EMG test consists of small thin needles inserted into several muscles to see if there are any nerve problems. I have been informed the Doctor will use a new needle and will dispose of the needle in a Sharps container. I have been informed that I may experience a small amount of pain when the needle is inserted. I have been informed that treatment may take 45 to 60 minutes. I have been informed not to wear lotion on the body part that is going to be tested and I may perform my normal activities, such as eating, driving, and exercising before and after the test.
I have been informed that NCS shows how the body's electrical signals are traveling to a nerve. This is done by applying small electrical shocks to the nerve and recording how the nerve works.

☐ **EVALUTION**

I have been informed that the Doctor will give me a physical exam, we will discuss my medical history, and the Doctor will make recommendations for further care.

- **Recommendations may include Chinese herbs and neutraceuticals that may be prescribed to you, the cost of these will be your responsibility at time of visit. If you think that either the herbs or neutraceuticals are causing a new symptom, discontinue these medications immediately. Wait and watch for changes in your symptoms, and call this office on the next working day.**

- **After – hours Availability:** Since we do not offer either urgent or emergency care. We require that all patients have a Primary Care Provider.

My signature certifies that I have read and understand the statements above.

Patient:____ Date:____________________
If patient is a minor, signature of parent or legal guardian

Witness:____ Date:____________________

ACKNOWLEDGEMENT OF

NOTICE OF PRIVACY PRACTICES

THE FOLLOWING SIGNED STATEMENT WILL BE FILED/INCLUDED IN YOUR MEDICAL RECORD CHART

I hereby acknowledge that I have received a copy of George Mars, MD's "Notice of Privacy Practices".

______________________________	______________________________
Print Name of Patient	Date
______________________________	______________________________
Signature of Patient/Parent/Representative	If Parent/Representative-Relationship

STANDARD PATIENT WAVIER FORM

As a condition of servicing the health care needs of the below referenced patient, I (the patient, legal guardian, subscriber) hereby attest that the patient is an "Eligible" member of the health plan listed below as of the date of service. I further hereby attest and agree that, should the patient later be determined "ineligible" for the services rendered by this provider, I shall comply with the demands of payment to provider.

IDENTIFYING INFORMATION (PLEASE PRINT):

PATIENT NAME:_____________________________________ **DATE OF BIRTH:**_____________

NAME OF INSURANCE COMPANY (S):____

SUBSCRIBER NAME: _______________________________________ **ID #:** __________________

HOME PHONE: __________________________ **WORK PHONE:** __________________________

EMPLOYER NAME: ____

EMPLOYER ADDRESS: ____

NOTES: ____

____

I hereby confirm that the above information is true and correct. I also agree to pay provider for services rendered if the Health Plan determines that I am not eligible for services rendered on this date of service.

____________________________________ ________________________ ____________
Signature of Patient/Subscriber/Guardian Relationship/Self Date