Acupuncture Patient Information

PATIENT INFORMATION

Date: _____

Name: _____

Address: _____

_____

City State Zip

Birthdate: _____

Gender: ☐ Male ☐ Female ☐ Other

Preferred Personal Pronouns: _____

☐ Single ☐ Married ☐ Significant Other

☐ Widowed ☐ Separated ☐ Divorced

Patient SS#: _____

Occupation: _____

Employer: _____

Emp. Address: _____

Emp. Phone: _____

Whom can we thank for referring you?

_____

INSURANCE INFORMATION

Insurance Carrier: _____

Relationship to Patient: _____

Insurance Company: _____

Group #: _____

Subscriber #: _____

Is patient covered by additional insurance: Yes No

ASSIGNMENT AND RELEASE

I, the undersigned, ceritify that I (or my dependent) have insurance coverage with _____ and assigned directly to _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am finacially repsonable for all charges whether or not paid by insurance. I hearby authorize the provider to release all information necessary to secure the payment f benefits. I authorize the use of this signature on all insurance sibmissions.

_____

Responsible Party Signature

_____

Relationship Date

CONTACT INFORMATION

Home: _____

Work: _____

Cell: _____

Best time & place to reach you: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Primary Phone: _____

Secondary Phone: _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date: _____

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Ins. ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (If applicable): _____

_____

GENERAL INFORMATION

Have you had acupuncture before? ☐ Yes ☐ No Have you used Chinese herbal medicine? ☐ Yes ☐ No

Are you currently under the care of a physician? ☐ Yes ☐ No If Yes, for what? _____

Physician's Name: _____ Physician's phone: _____

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PRESENT HEALTH CONCERNS

(Please list your most health concern in order of significance.)

1. _____ Approx. Date of Onset: _____
   Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
   Other therapies tried: ☐Medications ☐Surgery ☐Chiropractic ☐Phys. Therapy ☐Other: _____
2. _____ Approx. Date of Onset: _____
   Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
   Other therapies tried: ☐Medications ☐Surgery ☐Chiropractic ☐Phys. Therapy ☐Other: _____
3. _____ Approx. Date of Onset: _____
   Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
   Other therapies tried: ☐Medications ☐Surgery ☐Chiropractic ☐Phys. Therapy ☐Other: _____

Please list all medications that you are currently taking (or have used in the past two months), with dosages.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list any allergies (drug, foods or other): _____

HEALTH HISTORY

Past Medical History (Please list past injuries, broken bones, surgeries and hospitalizations & approx. dates)

_____

_____

_____

PERSONAL HABITS

☐ Tobacco packs/day _____
☐ Alcohol drinks/wk. _____
☐ Coffee/tea/soda cups/day _____
☐ Recreational Drugs times/wk. _____

☐ High Stress Level Reason _____

Do you follow any diet regimens/restrictions?
☐ Yes ☐ No
If yes, please describe: _____

WORK & EXERCISE HABITS

☐ Sitting % of time_____
☐ Standing % of time_____
☐ Light Labor % of time_____
☐ Heavy Labor % of time_____
☐ High Stress Level Reason _____

Do you exercise regularly? ☐ Yes ☐ No
If yes, please describe: _____

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Please check if you have had any of the following in the last three months:

General					
	Poor appetite		Fever/chills		Tremors
	Heavy appetite		Sweat easily		Poor sleeping
	Changes in appetite		Localized weakness		Heavy sleeping
	Weight loss/gain		Bleed/bruise easily		Dream disturbed sleep
	Cravings		Sudden energy drop (time?)		Night sweats
	Peculiar tastes		Dizziness		Strong thirst
	Fatigue				
Skin and Hair					
	Rashes/Hives		Ulcerations		Fungal infections
	Itching		Eczema/Psoriasis		Recent moles
	Dry Skin		Loss of hair		Change in hair/skin texture
	Dandruff		Pimples/acne		
Other hair or skin concerns:					
Head, Eyes, Ears, Nose & Throat					
	Concussions		Spots in front of eyes		Swollen glands
	Glasses/Contacts		Earaches/Infections		Sores on lips/tongue
	Red eyes		Poor hearing		Excessive saliva
	Itchy eyes		Sinus problems		Teeth problems
	Dry eyes		Post nasal drip		Gum problems
	Excessive tearing		Excessive phlegm – Color:		TMJ disorder
	Poor/blurry visions		Nose bleeds		Grinding teeth
	Night blindness		Cataracts/Glaucoma		Headaches (location, triggers, severity)
Other head & neck concerns:					
Cardiovascular					
	High blood pressure		Palpitations		Swelling of feet
	Low blood pressure		Fainting		Blood clots
	Chest pain		Cold hands/feet		Phlebitis
	Irregular heartbeat	Other:			
Respiratory					
	Cough		Pain with deep breath		Coughing blood
	Shortness of breath		Wheezing		Tight chest
	Asthma		Bronchitis		Pneumonia
	Production of phlegm: color thin/thick	Other:			

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Gastrointestinal

	Nausea		Belching		Abdominal pain
	Vomiting		Bad breath		Itchy anus
	Diarrhea		Blood in stool		Burning anus
	Constipation		Black stool		Hemorrhoids/fissures
	Gas/bloating		Mucus in stools		Hiccups
	Acid Regurgitations		History of chronic laxative use?	Other:	

Genitourinary

	Pain on urination		Bedwetting		Premature ejaculation
	Frequent urination		Kidney stones		Nocturnal emissions
	Blood in urine		Impotency		Sores on genitals
	Urgency to urinate		Increase libido		Frequent urinary tract infections
	Unable to hold urine		Decreased libido		Chronic yeast infections
	Decrease in flow		If you wake to urinate, how often:		

Other:

Musculoskeletal

	Neck Pain		Muscle Weakness		Knee pain
	Upper back pain		Cramps/spasms		Foot/ankle pain
	Lower back pain		General joint pain/stiffness		Hip pain
	Hand/wrist pains		Shoulder pain		Muscle pains
	Joint with limited range of motion				

Other:

Neuropsychological

	Seizers		Memory loss		Early susceptible to stress
	Loss of balance		Concussion		Tics
	Areas of numbness		Depression		Anxiety
	Irritability		Lack or coordination		History of emotional/physical abuse

Other:

Gynecology

Age of first menses:		If no longer menstruating, appx. date ceased:			
Date of last menses:		Length between menses: (days)		Duration of period: (days)	
	Heavy flow		Light flow		Clots in flow
	Painful periods		Vaginal discharge/ Color:		Vaginal sores
	Hot flashes		Irregular periods		Vaginal odor
	Brest lumps/sores	Changes in psyche prior to menstruation:			
Date of last PAP:		PAP results (normal, abnormal, unsure):			

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If you've used birth control, what type and for how long?
Have you ever used hormonal methods for contraception/period regulation? If so, what types?
Do you have any children? If yes, how many and what are their ages?

Pregnancy History

Number of pregnancies?	Births:	Miscarriages:	Abortions:
Were your pregnancies/births relatively normal? Explain:			
Are you currently pregnant? ☐ Yes ☐ No Due Date?			

Comments

Please let us know if there are any other concerns you would like to address.

Family History – please fill in boxes for each condition that applies to one of your family members.

	Yes	Who	Comments
Addiction (alcohol/drugs)			
Cancer			
Cardiac disorders (heart disease, high blood pressure, stroke)			
Diabetes			
Digestive/Gastrointestinal disorder			
Immune disorders (hepatitis, HIV, etc.)			
Mental illness			
Respiratory disorders (asthma, allergies, etc.)			
Skin disorders (eczema, psoriasis, etc.)			
Seizure disorders			

Signature: _____ Date:_____