PATIENT CONTACT INFORMATION

Name ____ Date__________
First Middle Last

Address ____________________________________ Occupation ____________
Street

____________________________________ Gender (circle) Male Female
City State Zip Code

Best contact phone number__________________________ Age _____ DOB____/____/____

May we send or email you newsletters/health related mailings? yes □ no □

Email ______________________________________

Note: email is not HIPAA compliant and therefore not the best way to communicate health issues with your doctor.

Emergency contact ____
Name Phone number Relationship

REASON FOR VISIT

What are your most important health concerns? Please list your present health concerns or symptoms:

HEALTH INFORMATION

Do you have any allergies? yes □ no □
Please list allergies to drugs, foods or environmental factors and your reactions below.

____

____

Do you take any of the following medications?

	No	Yes		No	Yes		No	Yes
Pain relievers (aspirin, ibuprofen, etc)	□	□	Antibiotics	□	□	Antacids	□	□
Blood thinners (warfarin, coumadin)	□	□	Heart medication	□	□	Laxatives	□	□
Cortisone (creams or pills)	□	□	Sleeping pills	□	□	Sedatives	□	□

Are you currently taking any prescription medications, over-the-counter medications, vitamins or other nutritional/herbal supplements? yes □ no □ If yes, please list them all below.

____

____

What hospitalizations, surgeries or serious illnesses have you had?

____

When was your last physical exam?__________________ How about blood work?______________

Have you ever had acupuncture before? yes □ no □

How did you hear about us? ____

What do you do to manage your stress levels/what is your favorite thing to do?

____

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PATIENT HEALTH HISTORY

Do you have a personal or family history of the following?

	No	Yes*
Anemia	☐	☐
Damaged heart valve	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Hay fever/hives	☐	☐
Stroke	☐	☐
Kidney disease	☐	☐
Cancer	☐	☐
Heart disease	☐	☐
Mental Illness	☐	☐
Thyroid problems	☐	☐
Diabetes	☐	☐
High blood pressure	☐	☐
Epilepsy	☐	☐
Hepatitis	☐	☐
Liver Disease	☐	☐
Tuberculosis	☐	☐
HIV	☐	☐
Other major disease	☐	☐

Describe___________________

Do you have any of the following symptoms/conditions? Circle if you have had them in the past.

	No	Yes		No	Yes		No	Yes
Cold hands/feet	☐	☐	Skin rashes	☐	☐	Jaw pain/TMJ	☐	☐
Numbness/tingling	☐	☐	Skin lumps	☐	☐	Ringing in the ears	☐	☐
Muscle aches	☐	☐	Loss of hair	☐	☐	Itching	☐	☐
Neck pain/stiffness	☐	☐	Diarrhea	☐	☐	Acne or boils	☐	☐
Back pain or Sciatica	☐	☐	Jaundice	☐	☐	Eye problems	☐	☐
Shooting pain	☐	☐	Constipation	☐	☐	Spitting up blood	☐	☐
Burning pain	☐	☐	Heartburn	☐	☐	Blood in stool	☐	☐
Migraines or headaches	☐	☐	Fainting	☐	☐	Ulcers	☐	☐
Varicose veins	☐	☐	Chest pain	☐	☐	Sinus problems	☐	☐
Pneumonia	☐	☐	Weakness	☐	☐	Head injury	☐	☐
Shortness of breath	☐	☐	Cramping	☐	☐	Paralysis	☐	☐
Frequent colds	☐	☐	Joint pain	☐	☐	Insomnia	☐	☐
Abdominal pain	☐	☐	Sore throat	☐	☐	Stress/irritability	☐	☐
Anxiety or depression	☐	☐	Fever	☐	☐	Sexual difficulty	☐	☐
Low blood pressure	☐	☐	Blood clots	☐	☐	Low libido	☐	☐
Easy bruising/bleeding	☐	☐	Cough	☐	☐	Gonorrhea	☐	☐
Night Sweats	☐	☐	Fatigue	☐	☐	Herpes	☐	☐
Loss of memory	☐	☐	Murmur	☐	☐	Chlamydia	☐	☐
Frequent urination	☐	☐	Dizziness	☐	☐	Other STD	☐	☐
Skin color changes	☐	☐	Seizures	☐	☐			

Describe:_________________

*if a family member please list who: mother (M), father (F), sister (S), grandfather (GF), etc.

Women only:

Do you have any of the following:

	No	Yes		No	Yes
Regular periods?	☐	☐	Uterine fibroids?	☐	☐
Painful menses?	☐	☐	Fertility issues?	☐	☐
Abnormal bleeding?	☐	☐	Breast tenderness?	☐	☐
Hot flashes?	☐	☐	Breast lumps?	☐	☐

Are you currently or possibly pregnant? No ☐ Yes ☐

Number of pregnancies: ________ Number of live births:_________

What type of birth control, if any ___________________________

Men only:

Do you have any of the following:

	No	Yes
Testicular mass?	☐	☐
Discharge?	☐	☐
Prostate issues?	☐	☐
Hernia?	☐	☐

PLEASE READ AND SIGN BELOW

I understand that my personal health information is confidential and consent to the use and disclosure of my health information for the purposes of treatment, payment and healthcare operations or as otherwise required by law. I have looked over and understand the HIPAA privacy policy.

I understand that my practitioner may leave a phone message for me regarding any pertinent health related information.

I understand and agree that all fees for professional services rendered on my behalf are my personal responsibility and due and payable at the times services are rendered unless other arrangements have been made in advance.

I understand that even if I am covered by my health insurance, it is possible I will still owe fees to the practitioner at a later date due to unforeseen restrictions or because my health insurance company may not cover services in full and I will remit payment to the clinic in a timely manner when requested to do so accordingly (past due invoices will be subject to a 1.5% finance charge; unpaid invoices that are 30 days past the 3rd & final notice will be handed off to collections).

Signature of Responsible Party____ **Date**______________________

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