

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)	<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Antacids	<input type="checkbox"/>	<input type="checkbox"/>
Blood thinners (warfarin, coumadin)	<input type="checkbox"/>	<input type="checkbox"/>	Heart medication	<input type="checkbox"/>	<input type="checkbox"/>	Laxatives	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone (creams or pills)	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives	<input type="checkbox"/>	<input type="checkbox"/>

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?

PATIENT HEALTH HISTORY

Do you have a personal or family history of the following?	Do you have any of the following symptoms/conditions? Circle if you have had them in the past.										
No	Yes*	No	Yes	No	Yes	No	Yes				
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Cold hands/feet	<input type="checkbox"/>	<input type="checkbox"/>	Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain/TMJ	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>	Skin lumps	<input type="checkbox"/>	<input type="checkbox"/>	Ringling in the ears	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Muscle aches	<input type="checkbox"/>	<input type="checkbox"/>	Loss of hair	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain/stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Acne or boils	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever/hives	<input type="checkbox"/>	<input type="checkbox"/>	Back pain or Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Eye problems	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Shooting pain	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Burning pain	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Migraines or headaches	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Cramping	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Stress/irritability	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety or depression	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Sexual difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Low libido	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising/bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>
Other major disease	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Other STD	<input type="checkbox"/>	<input type="checkbox"/>
Describe _____			Skin color changes	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____		

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

Women only:	Men only:																																										
Do you have any of the following: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">No</td> <td style="width: 50%;">Yes</td> <td style="width: 50%;">No</td> <td style="width: 50%;">Yes</td> </tr> <tr> <td>Regular periods?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Uterine fibroids?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Painful menses?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Fertility issues?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Abnormal bleeding?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Breast tenderness?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Hot flashes?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Breast lumps?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	No	Yes	No	Yes	Regular periods?	<input type="checkbox"/>	<input type="checkbox"/>	Uterine fibroids?	<input type="checkbox"/>	<input type="checkbox"/>	Painful menses?	<input type="checkbox"/>	<input type="checkbox"/>	Fertility issues?	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	Breast tenderness?	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes?	<input type="checkbox"/>	<input type="checkbox"/>	Breast lumps?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any of the following: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">No</td> <td style="width: 50%;">Yes</td> </tr> <tr> <td>Testicular mass?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Discharge?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Prostate issues?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Hernia?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	No	Yes	Testicular mass?	<input type="checkbox"/>	<input type="checkbox"/>	Discharge?	<input type="checkbox"/>	<input type="checkbox"/>	Prostate issues?	<input type="checkbox"/>	<input type="checkbox"/>	Hernia?	<input type="checkbox"/>	<input type="checkbox"/>
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Are you currently or possibly pregnant? No <input type="checkbox"/> Yes <input type="checkbox"/>																																											
Number of pregnancies: _____ Number of live births: _____																																											
What type of birth control, if any _____																																											

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 _____