



Name _____ Today's Date _____

Street Address _____ Apt. _____

City _____ State _____ Zip _____

Preferred Phone _____ Email _____

Birth Date (include year) _____ Age _____ Gender _____

Occupation _____ Employer _____

Referred by _____

Emergency Contact: Name _____ Phone (_____) _____ - _____

FEES:

It is our policy that you pay the entire session fee or co-pay at the time of each session.

We will provide a minimum of one month's notice of any changes to our fees.

Insurance Company _____

Insurance Company Phone Number (Provider Line) _____

ID # _____

Please bring a photocopy of your insurance card (front and back) or bring your card to your first appointment so we can make a copy at the clinic.

CANCELLATION POLICY:

If you need to change or cancel your appointment please do so with a minimum of 24 hours notice. Failure to do so will result in being charged the equivalent of the cash rate of the missed appointment to your account.

I understand the cancellation policy.

Signature: _____ Date: ____/____/____



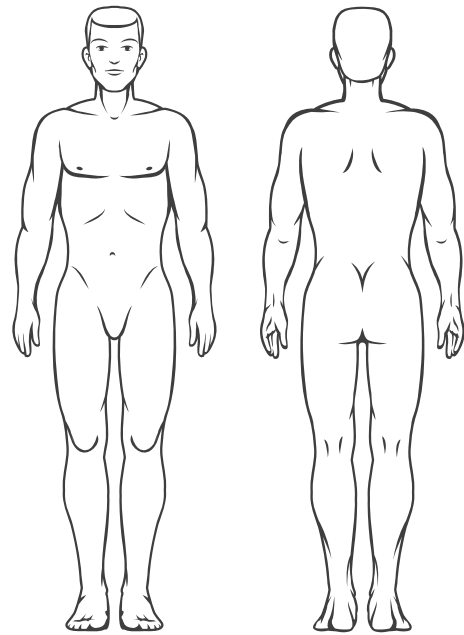
HEALTH HISTORY

Have you had acupuncture before? _____ If so, for what reason? _____

Main issue(s) you are seeking treatment for:

Please mark any areas of pain or discomfort:

Diagnosis from a medical professional (if applicable):



LEVEL OF DAILY PAIN

0 IS NO PAIN10 IS WORST PAIN

1 2 3 4 5 6 7 8 9 10

LEVEL OF PAIN WITH USE OR ACTIVITY

1 2 3 4 5 6 7 8 9 10

Please check any symptoms that you have experienced in the past or currently experience:

GENERAL

	past	current		past	current
sweating easily during the day	<input type="checkbox"/>	<input type="checkbox"/>	fatigue	<input type="checkbox"/>	<input type="checkbox"/>
night sweating	<input type="checkbox"/>	<input type="checkbox"/>	fevers	<input type="checkbox"/>	<input type="checkbox"/>
bleed or bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	chills	<input type="checkbox"/>	<input type="checkbox"/>
change in appetite	<input type="checkbox"/>	<input type="checkbox"/>	weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>
dizziness/vertigo	<input type="checkbox"/>	<input type="checkbox"/>	poor sleep	<input type="checkbox"/>	<input type="checkbox"/>


SKIN & HAIR

	past	current		past	current
rashes/hives	<input type="checkbox"/>	<input type="checkbox"/>	psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
eczema	<input type="checkbox"/>	<input type="checkbox"/>	loss of hair	<input type="checkbox"/>	<input type="checkbox"/>
acne	<input type="checkbox"/>	<input type="checkbox"/>			

HEAD, EARS, EYES, NOSE & THROAT

	past	current		past	current
earaches/pressure in the ears	<input type="checkbox"/>	<input type="checkbox"/>	headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>
ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>	sinus pressure	<input type="checkbox"/>	<input type="checkbox"/>
hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
eye floaters	<input type="checkbox"/>	<input type="checkbox"/>	dizziness/vertigo	<input type="checkbox"/>	<input type="checkbox"/>
itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	teeth/jaw clenching	<input type="checkbox"/>	<input type="checkbox"/>
blurry vision	<input type="checkbox"/>	<input type="checkbox"/>			

CARDIOVASCULAR/CIRCULATORY

	past	current		past	current
chest pain	<input type="checkbox"/>	<input type="checkbox"/>	swelling/edema	<input type="checkbox"/>	<input type="checkbox"/>
fainting	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>	low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
cold hands & feet	<input type="checkbox"/>	<input type="checkbox"/>			

RESPIRATORY

	past	current		past	current
pain on inhaling	<input type="checkbox"/>	<input type="checkbox"/>	sneezing	<input type="checkbox"/>	<input type="checkbox"/>
chest tightness	<input type="checkbox"/>	<input type="checkbox"/>	seasonal/other allergies	<input type="checkbox"/>	<input type="checkbox"/>
cough	<input type="checkbox"/>	<input type="checkbox"/>	phlegm production	<input type="checkbox"/>	<input type="checkbox"/>
asthma	<input type="checkbox"/>	<input type="checkbox"/>			

GENITO-URINARY

	past	current		past	current
difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>	urgent/frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	sores on genitals	<input type="checkbox"/>	<input type="checkbox"/>
pain upon urination	<input type="checkbox"/>	<input type="checkbox"/>	genital pain	<input type="checkbox"/>	<input type="checkbox"/>



NEUROLOGICAL/PSYCHOLOGICAL

	past	current		past	current
anxiety	<input type="checkbox"/>	<input type="checkbox"/>	poor memory	<input type="checkbox"/>	<input type="checkbox"/>
depression	<input type="checkbox"/>	<input type="checkbox"/>	quick temper	<input type="checkbox"/>	<input type="checkbox"/>
loss of balance/coordination	<input type="checkbox"/>	<input type="checkbox"/>	easily susceptible to stress	<input type="checkbox"/>	<input type="checkbox"/>
areas of numbness/paralysis	<input type="checkbox"/>	<input type="checkbox"/>			

DIGESTIVE

	past	current		past	current
heartburn	<input type="checkbox"/>	<input type="checkbox"/>	gas	<input type="checkbox"/>	<input type="checkbox"/>
belching	<input type="checkbox"/>	<input type="checkbox"/>	diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
bloating	<input type="checkbox"/>	<input type="checkbox"/>	constipation	<input type="checkbox"/>	<input type="checkbox"/>
nausea	<input type="checkbox"/>	<input type="checkbox"/>	abdominal pain/cramps	<input type="checkbox"/>	<input type="checkbox"/>
vomiting	<input type="checkbox"/>	<input type="checkbox"/>	mucus in stool	<input type="checkbox"/>	<input type="checkbox"/>
chronic bad breath	<input type="checkbox"/>	<input type="checkbox"/>	blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
sores on lips/tongue	<input type="checkbox"/>	<input type="checkbox"/>	hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>

FOR WOMEN ONLY:

	past	current		past	current
irregular periods	<input type="checkbox"/>	<input type="checkbox"/>	breast pain	<input type="checkbox"/>	<input type="checkbox"/>
painful periods	<input type="checkbox"/>	<input type="checkbox"/>	vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>
bleeding between periods	<input type="checkbox"/>	<input type="checkbox"/>	vaginal sores	<input type="checkbox"/>	<input type="checkbox"/>
period clots	<input type="checkbox"/>	<input type="checkbox"/>	hot flashes	<input type="checkbox"/>	<input type="checkbox"/>
menstrual cramping	<input type="checkbox"/>	<input type="checkbox"/>	night sweating	<input type="checkbox"/>	<input type="checkbox"/>

age of first menses _____ duration of typical period _____

duration of typical cycle _____ date of last PAP _____

of pregnancies _____ # of live births (+ years) _____

of miscarriages _____ # of abortions _____

Have you been through menopause? Age? _____

Have you ever taken birth control pills? When and for how long? _____

Other premenstrual & menstrual symptoms (bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.)



FOR MEN ONLY:

	past current			past current	
erectile dysfunction/impotence	<input type="checkbox"/>	<input type="checkbox"/>	ejaculatory pain	<input type="checkbox"/>	<input type="checkbox"/>
varicocele	<input type="checkbox"/>	<input type="checkbox"/>	BPH	<input type="checkbox"/>	<input type="checkbox"/>

LIFESTYLE

Current medications/herbs/supplements:

Do you follow any certain diet or way of eating? (vegetarian, gluten-free, paleo, etc.)

Current exercise routine:

Do you use tobacco? If so, how often?

Do you drink alcohol? If so, how many drinks/week?



Are you currently taking any of the following medications? (circle if yes and indicate how often)

Advil/Motrin/Ibuprofen

Aleve/Naproxen

Bayer/Aspirin

Celebrex/Celecoxib

Prednisone/Prednisolone

Are you currently taking any other pain medications? If yes, list name and amounts per day:

Three horizontal lines for listing other pain medications.

Allergies (medications/foods/chemicals/etc.):

Three horizontal lines for listing allergies.

Have you ever had a seizure? If yes, indicate date of last: _____

PLEASE CIRCLE ANY SIGNIFICANT ILLNESSES AND INDICATE DATE: _____

Cancer Hepatitis Diabetes

High blood pressure Epilepsy Heart Attack

Stroke Ulcer Disease Liver Disease

Colon Polyps Other _____

Please list any major surgeries/hospitalizations and approximate dates:

Three horizontal lines for listing major surgeries/hospitalizations.



FAMILY MEDICAL HISTORY

- Cancer Seizures High blood pressure Stroke Diabetes
 Heart Attack Hepatitis Asthma Other _____

Please list any other relevant information or issues you would like to discuss:

Thank you for taking the time to fill out these forms. Please let us know if you have any questions or concerns.