

Welcome! Please be complete and accurate. Your answers to the following questions are the first step in determining your immediate and long-term healthcare needs. Please elaborate on any questions or add any comments you may have. The more we know about your needs and concerns, the better we can serve you. Be assured that your information is held in the utmost confidentiality. Thank you!

Patient Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 E-mail _____ Referred by _____
 Birth Date _____ Male Female Trans Height _____ Weight _____
 Marital Status S M DP W D # Children & Ages _____ Occupation _____

What are your treatment goals?

- Temporary relief of symptoms/pain management
- Eliminate root/cause of my health concern (if possible)
- Maintain care (Periodic balancing/tune-up to maintain current level of health)
- Other (Explain) _____

Are you under the care of a physician? No Yes For what conditions? _____

Please describe your current health problem(s) _____

How and when did it begin? _____ Is it work related? No Yes

What treatment have you received for the above? Surgery Medications Phys. Therapy Injections Massage Chiropractic
 Other _____

What has been your progress? Worse No change 25% better 50% better 75% better Other _____

Please check your pain areas and rate the amount of pain (0=No Pain, 10=Unbearable Pain)

| | | | |
|---|---|---|--|
| <input type="checkbox"/> Head _____ | <input type="checkbox"/> Elbow L _____ R _____ | <input type="checkbox"/> Tailbone L _____ R _____ | <input type="checkbox"/> Foot L _____ R _____ |
| <input type="checkbox"/> Neck _____ | <input type="checkbox"/> Hand L _____ R _____ | <input type="checkbox"/> Hip L _____ R _____ | <input type="checkbox"/> Chest L _____ R _____ |
| <input type="checkbox"/> Jaw L _____ R _____ | <input type="checkbox"/> Wrist L _____ R _____ | <input type="checkbox"/> Thigh L _____ R _____ | <input type="checkbox"/> Abdomen L _____ R _____ |
| <input type="checkbox"/> Shoulder L _____ R _____ | <input type="checkbox"/> Upper Back L _____ R _____ | <input type="checkbox"/> Knee L _____ R _____ | <input type="checkbox"/> _____ L _____ R _____ |
| <input type="checkbox"/> Arm L _____ R _____ | <input type="checkbox"/> Lower Back L _____ R _____ | <input type="checkbox"/> Ankle L _____ R _____ | <input type="checkbox"/> _____ L _____ R _____ |

Do you have or have you had any of the following?

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Alcohol/Drug Dependence | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Hospitalizations/ Surgical Procedures | <input type="checkbox"/> Thyroid Disorder _____ |
| <input type="checkbox"/> Abnormal Menstruation | <input type="checkbox"/> Fainting or Dizziness | _____ | <input type="checkbox"/> Tobacco Use Type: _____ |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Kidney Disease | Frequency ____/Day |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Fever | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Arthritis/Rheumatoid Arthritis | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Headache | <input type="checkbox"/> Pacemaker | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Palpitation/Arrhythmia | _____ |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Heartburn or Indigestion | <input type="checkbox"/> Peptic Ulcer | _____ |
| <input type="checkbox"/> Breast Lumps | <input type="checkbox"/> Heart Disease Type/Meds: _____ | <input type="checkbox"/> Pregnant, # Weeks _____ | _____ |
| <input type="checkbox"/> Cancer/Tumor Where? _____ | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Prostate Problems | _____ |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Weight Gain/Loss | _____ |
| <input type="checkbox"/> Diabetes How Controlled? _____ | <input type="checkbox"/> High Cholesterol/ Triglycerides | <input type="checkbox"/> Sinusitis | _____ |
| <input type="checkbox"/> Diarrhea/Constipation | | <input type="checkbox"/> Stomach Disorder | _____ |
| | | <input type="checkbox"/> Stroke | _____ |

Please check any you have had removed: Gallbladder Uterus or Ovaries Appendix Thyroid
 Tonsils & Adenoids Any other body parts removed? _____

Have you had any fractures, accidents, other surgeries, or serious illnesses? _____

If so, please list and include dates: _____

Have you ever been treated by a chiropractor, acupuncturist, or holistic health practitioner? If so, by whom, when, and for what?

Contagious History

Have you had or do you have a contagious illness that may require special procedures to protect our staff and others?

- Hepatitis
- HIV
- Tuberculosis
- Herpes
- Venereal Disease
- Other _____

Family History

| | Diabetes | Heart | Hypertension | Cancer | Thyroid |
|---------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Mother | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Father | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sibling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Medications (Please list all)

Please note any additional important information related to your health in the box below:

I certify that the above information is complete and accurate to the best of my knowledge. If the health plan information is not accurate, or if I am not eligible to receive health care benefits through this provider, I understand that I am liable for all charges for services. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage. I understand that my provider of acupuncture services may need to contact my Primary Care Physician or treating physician if my condition needs to be co-managed. Therefore, I give authorization to my provider of acupuncture services to contact my medical doctor if necessary.

Patient Signature

Date