TRIPOINT
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Initial Health Status

Geoff Thomas, DAOM, L.A.c., C.SMA

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!

Address City State Zip Home Phone Cell Phone Cell Phone	Patient Name			Date					
E-mail Referred by Birth Date O Male Female Height Weight Marital Status O S O M O # Children & Ages Occupation What are your treatment goals? Maintain care (Periodic balancing/tune-up to maintain current level of health) Eliminate root/cause of my health concern (if possible) O ther (Explain)									
E-mail Referred by Birth Date O Male Female Height Weight Marital Status O S O M O # Children & Ages Occupation What are your treatment goals? Maintain care (Periodic balancing/tune-up to maintain current level of health) Eliminate root/cause of my health concern (if possible) O ther (Explain)	Home Phone	Work Phone		Cell Pho	one				
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What treatment have you received for the above? Surgery Medications Phys. Therapy Injections Massage Chiropractic Other	How and when did it begin?								
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) Head Elbow R Tailbone R Foot R Neck Hand R Hip R Chest R Jaw R Upper Back R Thigh R Abdomen R Shoulder R Upper Back R Ankle R L R Arm L R Lower Back R Ankle R Thyroid Disorder Allergies Fatigue Fatigue Kidney Disease Type: Type: Frequency //Day Athritis/Rheumatoid Arthritis Frequent Urination Osteoporosis Discemaker Other Day Astima Heat Attack Palpitation/Arrhythmia Palpitation/Arrhythmia Other Other	•		-	/з. тпегару 🗆 г					
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Neck Hand R Hip R Chest R Jaw R Wrist R Thigh R Abdomen R Shoulder R Upper Back R Knee R Abdomen R Arm R Lower Back R Ankle R Ankle R R R Do you have or have you had any of the following? Ankle R Introvid Disorder R Introvid Disorder Alcohol/Drug Dependence Excessive Thirst Hospitalizations/ Thyroid Disorder Allergies Fatigue Migna Fever Kidney Disease Type: Frequency									
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Blood Disorder Heartburn or Indigestion Pentic Lilcer									
		-	-	-					
L Breast Lumps L Heart Disease	Breast Lumps		-						
	Cancer/Tumor	Type/meds.							
		□ Hiatial Hernia							
	Convulsions/SeizuresDiabetes		-						
How Controlled?		-							
	□ Diarrhea/Constipation								

Please check any you	have had	removed:	🗆 Ga
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allbladder □ Tonsils & Adenoids Uterus or Ovaries Any other body parts removed? ______

□ Thyroid

□ Appendix

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		Family History					
Have you had or do you have a contagious illness that may			Diabetes	Heart	Hypertension	Cancer	Thyroid
require special procedures to protect our staff and others?		Mother					
	Hepatitis	Father					
	HIV	Sibling					
	Tuberculosis	-					
	Herpes						
	Venereal Disease						
	Other						
Me	edications (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