TRIPOINT HOLISTIC THERAPY
858.576.7494
Geoff@TripointTherapy.com | TripointTherapy.com
5252 Balboa Avenue, Suite 804 | San Diego, CA 92117

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!

Patient Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail _____ Referred by _____

Birth Date _____ ◉ Male ○ Female Height _____ Weight _____

Marital Status ○ S ○ M ○ W ○ D # Children & Ages _____ Occupation _____

What are your treatment goals?

☐ Temporary relief of symptoms/pain management ☐ Maintain care (Periodic balancing/tune-up to maintain current level of health)

☐ Eliminate root/cause of my health concern (if possible) ☐ 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)

☐ Head	_____	☐ Elbow	L_____ R_____	☐ Tailbone	L_____ R_____	☐ Foot	L_____ R_____
☐ Neck	_____	☐ Hand	L_____ R_____	☐ Hip	L_____ R_____	☐ Chest	L_____ R_____
☐ Jaw	L_____ R_____	☐ Wrist	L_____ R_____	☐ Thigh	L_____ R_____	☐ Abdomen	L_____ R_____
☐ Shoulder	L_____ R_____	☐ Upper Back	L_____ R_____	☐ Knee	L_____ R_____	☐ _____	L_____ R_____
☐ Arm	L_____ R_____	☐ Lower Back	L_____ R_____	☐ Ankle	L_____ R_____	☐ _____	L_____ R_____

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

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

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	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Sibling	☐	☐	☐	☐	☐

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

SAVE SUBMIT PRINT CLEAR

Please complete this form, sign it, and bring it with you to your appointment. Thank you!