

New Patient Information

Name _____ Today's Date _____
Street Address _____ Unit _____
City _____ State _____ Zip _____
Preferred Phone _____ Email _____
Birth Date (include year) _____ Age _____
Gender _____ Height _____ Weight _____
Occupation _____ Employer _____
Marital Status _____ Referred by _____
Emergency Contact: Name _____ Phone _____
Primary Care Physician: Name _____ Phone _____

Other Practitioners Involved In Your Care:

Name _____ Phone _____
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 # _____

We are out of Network with insurance. If you want us to verify your acupuncture benefits then 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 notify us within a minimum of 48 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:** ____/____/____

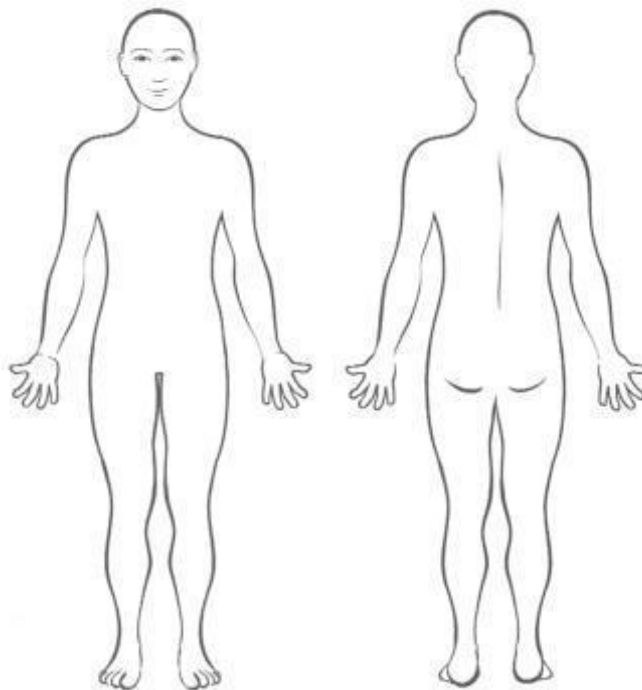
Health History:

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

Main issue(s) you are seeking treatment for and length of time experiencing each: _____

Diagnoses from a medical professional and approximate dates of diagnosis (if applicable):

Please mark any areas of pain or discomfort:



Please list areas of pain or discomfort below with the 1-10 pain scale and a brief history:

(1: barely noticeable pain, 10: excruciating pain)

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"/>	loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>
weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	increase in appetite	<input type="checkbox"/>	<input type="checkbox"/>
brain fog or confusion	<input type="checkbox"/>	<input type="checkbox"/>	trouble falling asleep	<input type="checkbox"/>	<input type="checkbox"/>
dizziness/vertigo	<input type="checkbox"/>	<input type="checkbox"/>	trouble staying asleep	<input type="checkbox"/>	<input type="checkbox"/>
fatigue during the day	<input type="checkbox"/>	<input type="checkbox"/>	swollen/sore lymph nodes	<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"/>	autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>

Please elaborate:

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"/>	itchy skin	<input type="checkbox"/>	<input type="checkbox"/>
dry skin	<input type="checkbox"/>	<input type="checkbox"/>	acne	<input type="checkbox"/>	<input type="checkbox"/>
oily skin	<input type="checkbox"/>	<input type="checkbox"/>	loss of hair/thinning hair	<input type="checkbox"/>	<input type="checkbox"/>

Please elaborate:

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"/>	sore throat	<input type="checkbox"/>	<input type="checkbox"/>
vision loss	<input type="checkbox"/>	<input type="checkbox"/>	swollen throat	<input type="checkbox"/>	<input type="checkbox"/>

Please elaborate:

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"/>	palpitations	<input type="checkbox"/>	<input type="checkbox"/>
heart arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>			

Please elaborate:

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"/>	nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>
wheezing	<input type="checkbox"/>	<input type="checkbox"/>	difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
pain behind the eyes	<input type="checkbox"/>	<input type="checkbox"/>			

Please elaborate:

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"/>
STD	<input type="checkbox"/>	<input type="checkbox"/>	yeast infections	<input type="checkbox"/>	<input type="checkbox"/>
bacterial vaginosis	<input type="checkbox"/>	<input type="checkbox"/>			

Please elaborate:

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"/>	mood swings	<input type="checkbox"/>	<input type="checkbox"/>
irritability	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Parkinsons	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>

Please elaborate:

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"/>

Please elaborate:

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 _____

Are you currently pregnant or breastfeeding? _____

Have you been through menopause? Age? _____

Did you experience a difficult menopause?

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.)

Please elaborate on any of the above:

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

BPH

Please elaborate:

Lifestyle:

Current medications/herbs/supplements (please list dosages and how long you have been taking each):

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

How much water do you drink per day? Is it filtered and if so, which type of filter do you use?

Have you used antibiotics in the past? If so, when and how often?

Current exercise routine:

Do you or have you ever used tobacco? If so, how often?

Do you or have you ever drank alcohol heavily? If so, how many drinks/week?

Do you or have you ever taken recreational drugs? If so, how often?

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

Advil/Motrin/Ibuprofen

Aleve/Naproxen

Prednisone/Prednisolone

Celebrex/Celecoxib

Bayer/Aspirin

Acetaminophen/Tylenol

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

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:

Family Medical History:

Cancer Seizures High blood pressure Stroke Diabetes

Heart Attack Hepatitis Asthma Other _____

What are your goals for your health?

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.