



ACUPUNCTURE PATIENT INFORMATION

NAME: _____ Date: _____

Best Phone #: _____ Alternate Phone #: _____

Address: _____ City/ST/Zip: _____

Email _____ May we add you to our mailing list? Yes No

Age: _____ Birth Date: _____ Marital Status: _____ Occupation: _____

EMERGENCY CONTACT/GUARDIAN: _____ Phone: _____

Referred by: _____

Insurance Company: _____ Social Security Number: _____
Primary Member: _____ Policy Number: _____
Group Number: _____ Provider Customer Service Phone Number: _____

I give my practitioner permission to bill my insurance company. If my claims are denied, I agree to promptly pay the regular fee per service received. Signature: _____

Current reason(s) for seeking treatment? _____

What results would you like to obtain? _____

How long have you had this condition? _____ Cause? _____

What makes it better? _____ Worse? _____

Has this condition been diagnosed by an MD? No Yes, Diagnosis: _____

Other professional treatments you are receiving: _____

Other things you are doing to help yourself: _____

Please list the medications, over-the-counter drugs, and supplements you are currently taking:

Table with 4 columns: Medication/Supplement, Reason for Taking, Dosage, When Prescribed?

For your safety, your acupuncturist must know if you have any of the following conditions:

- Diabetes: Type 1 / Type 2 (circle) Blood Pressure: High Low Lymphedema Anemia
Taking Blood Thinners/Coumadin/Warfarin Cancer: Dizziness/Vertigo
PACEMAKER Seizures HIV/AIDS Hepatitis A B C Hemophilia High Cholesterol
Stroke Ulcer Heart Disease Kidney Disease Thyroid Disease Other:

Women: Date of Last Period _____ Pregnant? No Yes _____ Nursing? No Yes

Anything you wish to add? _____

The above information is true to the best of my knowledge. If there is any change to my medical status or medications, I will inform my healthcare provider. I have read/received the Privacy Practices Notice. I understand that there is a 24-hour cancellation policy, and I may be billed for missed appointments.

Signature: _____ Date: _____

Payment is due in full at time of service unless prior arrangements have been approved.

PLEASE CHECK ALL SYMPTOMS WHICH BEST DESCRIBE YOUR TENDENCIES IN THE PAST 6 MONTHS, OR SPECIFY WHEN YOU EXPERIENCED THEM. These are significant even if they aren't problematic for you!

| BODY TEMPERATURE | | TASTE & MOUTH | | SLEEP | |
|--------------------------|--------------------------------------|--------------------------|------------------------------------|--------------------------|---|
| <input type="checkbox"/> | Hot Body Temperature (sensation) | <input type="checkbox"/> | Bitter Taste in Mouth | <input type="checkbox"/> | HOURS PER NIGHT |
| <input type="checkbox"/> | Cold Body Temperature (sensation) | <input type="checkbox"/> | Bland/Tasteless | <input type="checkbox"/> | Good Sleep/Feel Rested |
| <input type="checkbox"/> | Warm at night | <input type="checkbox"/> | Mouth Sores (canker) | <input type="checkbox"/> | Poor Quality Sleep |
| <input type="checkbox"/> | Heat in Chest/Face/Palms | <input type="checkbox"/> | Tongue Sores/Pain | <input type="checkbox"/> | Insomnia |
| <input type="checkbox"/> | Hot Flashes | <input type="checkbox"/> | Bleeding Gums or Gum Disease | <input type="checkbox"/> | Insomnia w/ Restlessness |
| <input type="checkbox"/> | Cold Hands/Feet | <input type="checkbox"/> | Foul Breath | <input type="checkbox"/> | Difficulty Falling Asleep |
| <input type="checkbox"/> | Cold or Heat Sensations with Pain | <input type="checkbox"/> | Dry Lips/Mouth | <input type="checkbox"/> | Difficulty Staying Asleep |
| <input type="checkbox"/> | | <input type="checkbox"/> | Profuse Saliva | <input type="checkbox"/> | Restless Sleep/Light Sleeper |
| <input type="checkbox"/> | | <input type="checkbox"/> | Tooth Problems: _____ | <input type="checkbox"/> | Intense Dreams |
| <input type="checkbox"/> | SWEAT | <input type="checkbox"/> | | <input type="checkbox"/> | Wake to Urinate, # _____ |
| <input type="checkbox"/> | Profuse Sweat (with little activity) | <input type="checkbox"/> | | <input type="checkbox"/> | Easy back to sleep after waking |
| <input type="checkbox"/> | No Sweat or very little sweat | <input type="checkbox"/> | DEFECATION | <input type="checkbox"/> | Difficult back to sleep after waking |
| <input type="checkbox"/> | Spontaneous Sweat (w/out activity) | <input type="checkbox"/> | Daily Bowel Movements: # _____ | <input type="checkbox"/> | Deep Sleeper / Difficult Waking |
| <input type="checkbox"/> | Night Sweats | <input type="checkbox"/> | Irregular Stools: Every _____ Days | <input type="checkbox"/> | Can Sleep All Day |
| <input type="checkbox"/> | Hands/Feet Sweat | <input type="checkbox"/> | Alternating Loose/Hard Stool | <input type="checkbox"/> | Snoring |
| <input type="checkbox"/> | Oily Sweat. With odor? Y N | <input type="checkbox"/> | Constipation | <input type="checkbox"/> | |
| <input type="checkbox"/> | | <input type="checkbox"/> | Dry Stool | <input type="checkbox"/> | |
| <input type="checkbox"/> | | <input type="checkbox"/> | Hard/Pebbly Stool | <input type="checkbox"/> | ENERGY & STAMINA |
| <input type="checkbox"/> | THIRST | <input type="checkbox"/> | Soft/Mushy Stools | <input type="checkbox"/> | High Energy, Good Stamina |
| <input type="checkbox"/> | Thirsty Regularly | <input type="checkbox"/> | Loose Stools | <input type="checkbox"/> | Low Energy, Fatigue |
| <input type="checkbox"/> | Thirsty with desire for cold drinks | <input type="checkbox"/> | Loose Stool in Morning | <input type="checkbox"/> | Fatigue in the Afternoon |
| <input type="checkbox"/> | Dry Mouth, Little Thirst | <input type="checkbox"/> | Diarrhea | <input type="checkbox"/> | Exhausted After Sex |
| <input type="checkbox"/> | Dry Mouth & Thirst at Night | <input type="checkbox"/> | Undigested Food in Stool | <input type="checkbox"/> | |
| <input type="checkbox"/> | No Thirst or very little thirst | <input type="checkbox"/> | Blood or Mucous in Stool | <input type="checkbox"/> | EMOTIONAL TENDENCIES |
| <input type="checkbox"/> | | <input type="checkbox"/> | Painful Defecation | <input type="checkbox"/> | Irritability/Anger |
| <input type="checkbox"/> | DIGESTION | <input type="checkbox"/> | Pain after Defecation | <input type="checkbox"/> | Joy/Excitement/Talkativeness |
| <input type="checkbox"/> | Excessive Appetite | <input type="checkbox"/> | | <input type="checkbox"/> | Worry/Over-thinking/Pensiveness |
| <input type="checkbox"/> | Low Appetite | <input type="checkbox"/> | | <input type="checkbox"/> | Sadness/Grief/Crying |
| <input type="checkbox"/> | Sudden Weight Gain or Loss | <input type="checkbox"/> | URINATION | <input type="checkbox"/> | Fear/Anxiety/Shock |
| <input type="checkbox"/> | Nausea/Vomiting | <input type="checkbox"/> | Frequent | <input type="checkbox"/> | Depressed/Unhappy |
| <input type="checkbox"/> | Stomach Pain | <input type="checkbox"/> | Urgent | <input type="checkbox"/> | Indecisive/Lack of Direction |
| <input type="checkbox"/> | Hiccoughs | <input type="checkbox"/> | Clear/Profuse | <input type="checkbox"/> | |
| <input type="checkbox"/> | Gas | <input type="checkbox"/> | Dark Color/Small Amount | <input type="checkbox"/> | SENSITIVE TO: (or dislike of...) |
| <input type="checkbox"/> | Bloating | <input type="checkbox"/> | Burning/Painful | <input type="checkbox"/> | Wind |
| <input type="checkbox"/> | Tired After Eating | <input type="checkbox"/> | Cloudy Urine | <input type="checkbox"/> | Heat |
| <input type="checkbox"/> | Gurgling Sounds | <input type="checkbox"/> | Incontinence | <input type="checkbox"/> | Dampness/Humidity |
| <input type="checkbox"/> | Acid Reflux/GERD | <input type="checkbox"/> | Stress Incontinence | <input type="checkbox"/> | Dryness |
| <input type="checkbox"/> | Hiatal Hernia | <input type="checkbox"/> | Nighttime Urination (# _____) | <input type="checkbox"/> | Cold |
| <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | Frequent Bladder Infections | <input type="checkbox"/> | Weather Changes |
| <input type="checkbox"/> | Heart Burn | <input type="checkbox"/> | Blood in Urine | <input type="checkbox"/> | Favorite Season? _____ |
| <input type="checkbox"/> | Belching | <input type="checkbox"/> | Kidney Infections or Stones | <input type="checkbox"/> | |
| <input type="checkbox"/> | Mouth Sores (canker) | <input type="checkbox"/> | | <input type="checkbox"/> | |
| <input type="checkbox"/> | Other: _____ | <input type="checkbox"/> | | <input type="checkbox"/> | |
| <input type="checkbox"/> | | <input type="checkbox"/> | STRESS LEVEL | <input type="checkbox"/> | HEAD |
| <input type="checkbox"/> | | <input type="checkbox"/> | Extremely High | <input type="checkbox"/> | Headaches, Location: _____ |
| <input type="checkbox"/> | PREFERRED FLAVORS | <input type="checkbox"/> | High | <input type="checkbox"/> | Migraines |
| <input type="checkbox"/> | Sour/Vinegar | <input type="checkbox"/> | Moderate / Normal | <input type="checkbox"/> | Poor Memory: Long Term or Short |
| <input type="checkbox"/> | Bitter/Tart | <input type="checkbox"/> | Low | <input type="checkbox"/> | Foggy Mind, Heavy Head |
| <input type="checkbox"/> | Sweet/Sugary | <input type="checkbox"/> | Source of Stress: _____ | <input type="checkbox"/> | Mental Confusion |
| <input type="checkbox"/> | Pungent/Spicy | <input type="checkbox"/> | | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | Salty | <input type="checkbox"/> | | <input type="checkbox"/> | Head Injury or Stroke _____ |

