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PERSONAL INFORMATION (Confidential)

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Email: _____

Occupation: _____ Work/Mobile Phone: _____

Emergency Contact: _____ Phone: _____

Who should we thank for Referring you to this office? _____

Sex: ☐ Male ☐ Female ☐ Trans

Birthdate: _____ Age: _____ Height: _____ Weight: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnered # of Children: _____

Have you received Acupuncture Before: Yes / No When? _____ For how long? _____

Please indicate any significant illnesses you or a blood relative (Grandparent, Parent, Sibling) have had:

Illness	You	Your Relative	Approx Date	Illness	You	Your Relative	Approx Date
Diabetes	☐	☐	_____	Cancer	☐	☐	_____
Heart Disease	☐	☐	_____	Hepatitis	☐	☐	_____
Seizures	☐	☐	_____	High Blood Pressure	☐	☐	_____
Emotional Disorders	☐	☐	_____	Rheumatic Fever	☐	☐	_____
Tuberculosis	☐	☐	_____	Infectious Disease	☐	☐	_____

Sexually Transmitted Diseases:

☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ HPV ☐ Chlamydia ☐ Herpes Date: _____

List any medications and supplements you are currently taking: (continue on Back if necessary)

Medicine	Dosage	Reason	How Long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please Circle Y or N:

Do you have any allergies: Y / N

Are you taking Coumadin/Warfarin: Y / N

Do you have a pacemaker: Y / N

Do you smoke Tobacco: Y / N How Much? _____

Do you take recreational drugs: Y / N

Do you drink Alcohol: Y / N How Much? _____

List allergies or food sensitivities you have: _____

WOMENS - OB / GYN HISTORY

Age of 1st Period: _____ Are you Pregnant? Yes / No # of Pregnancies: _____

Age of Last Period (Menopause): _____ # of Live Births_____ # Abortions: _____ # Miscarriages: _____

Number of days between periods: _____ Date of last GYN exam: _____ Pap Smear: _____

Number of days of flow: _____ Mammogram: _____ Results: _____

Amount of Flow: ☐ Light ☐ Moderate ☐ Heavy Explain:_____

Color of Flow: (Light Red, Red, Dark Red, Brownish, Purplish) _____ Cloths? Y / N Color:_____

Have you been diagnosed with: ☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ PID

Other:_____ Do you get Cramps or Pain? Y / N Location? _____

Nature of Pain (Please indicate if before, during or after menses):_____

☐ Cramping ☐ Stabbing
☐ Burning ☐ Aching
☐ Dull ☐ Bloating
☐ Consistent ☐ Intermittent
☐ Bearing Down Sensation

Other Symptoms Related to Menses:

☐ Discharge ☐ Mood Swings ☐ Increase Appetite
☐ Nausea ☐ Hot Flashes ☐ Night Sweats
☐ Swollen Breast ☐ Headache ☐ Insomina
☐ Constipation ☐ Diarrhea Other:_____

MENS - UROGENITAL HISTORY

Date of last prostate check up: _____ PSA Results: _____ Manual prostate exam results:_____

Lab Results:_____

Do you have frequent of urination? Y / N Nighttime Frequency? _____ Color of Urine? _____ Odor: Y / N

Symptoms related to Prostate:

☐ Prostate Problems ☐ Delayed Stream ☐ Decrease Libido ☐ Premature Ejaculation
☐ Erectile Dysfunction ☐ Increase Libido ☐ Testicular Pain ☐ Decrease Force of stream
☐ Back Pain ☐ Groin Pain ☐ Incontinence ☐ Retention of Urine
☐ Other:_____ ☐ Impotence ☐ BPH/Enlarge Prostate

SYMPTOM SURVEY (Check all that apply)

__Lack of Appetite
__Excessive Appetite
__Loose stool or Diarrhea
__Digestive Problems, Indigestion
__Vomiting, Belching, Burping
__Heartburn, Reflux
__Feeling of Retention of food in Stomach
__Tendency to become obsessive in work, exercise, relationships
__Insomnia, Difficulty Sleeping
__Heart Palpitations
__Cold Hands & Feet
__Nightmares
__Mentally restless
__Laughing for no reason
__Angina pains
__Abdominal pain
__Chest pain
__Sciatic pain
__Headaches
__Pain or coldness in genital area
__Cough
__Shortness of breath
__Decreased sense of smell
__Nasal Problems
__Skin problems
__Feeling of Claustrophobia
__Bronchitis
__Colitis, Diverticulitis
__Constipation
__Hemorrhoids
__Recent use of Antibiotics
__Eye problems
__Jaundice (Yellowish of Eyes or Skin)
__Difficulty digesting oily food
__Gallstones
__Light colored stool
__Soft brittle nails
__Easily angered or agitated
__Difficulty making decisions or plans
__Spasms or Twitching of Muscles
__Low back pain
__Knee Problems
__Hearing Impairment
__Ear Ringing
__Kidney Stones
__Decreased sex drive
__Hair loss
__Urinary problems
__Fatigued
__Edema
__Blood in stool
__Black tarry stool
__Easily bruised
__Difficult to stop bleeding
__Asthma
__Tendency to catch colds easily
__Intolerant to weather changes
__Allergies
__Hay fever
__Dizziness
__Tendency to faint easily
__High Cholesterol
__Sudden weight loss

What are the main Health problems for which you are seeking treatment?

_____

_____

_____

What other forms of treatment have you sought?

_____

List any other health problems you have:

_____

List any accidents, surgeries or hospitalizations (Include date):

_____

Lab Results: (please include copies if any):_____

_____

CLINICAL NOTES (HPI) ** Practitioner Notes**

(Onset, Location, Duration, Characteristics, Aggravate/ Alleviate, Related Factors, Treatment, Significance)

_____
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Treatment Plan: _____
TCM Differential Diagnosis: _____
Exam/Test to monitor: _____
Research to do: _____
Referrals to make: _____
Pt Education/recommendations: _____
Recent Changes to Meds/Supplements: _____

PULSE

Right	Left
_____	_____
_____	_____
_____	_____

Heart Rate:_____

TONGUE	
Color:	
Shape:	
Coating:	
Sublinguals:	

Cancelation and Payment Policy

We kindly ask all new patients to read the following and provide a signature where indicated.

Payment Policy

All Services and herbs are payable at the time they are received. You are responsible for co-pays, deductibles and cost of treatment at the time of service.
Many insurance policies do cover acupuncture but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductibles and percentage of coverage for acupuncture care. We will provide you with the proper documentation necessary for individual reimbursement by your Insurance.

Cancelation Policy

Please contact us via phone or email **AT LEAST 24 hours** prior to your scheduled appointment date and time to avoid cancellation fees.

We reserve an appointment time for you and ask that you call us if you cannot keep your appointment. In consideration of other folks who may be on a waiting list for appointments, we ask that you give us at least 24 hours' notice in advance of an appointment that you'll not be able to keep. All appointments that are cancelled with less than 24 hours notice, or are missed altogether without letting us know, will be charged a $50 fee payable at the next visit. We do also recognize that emergencies happen, and would be happy to consider these on an individual basis, or course. Thanks for understanding and in doing so, helping us to keep our fees as low as possible.

We thank you for your consideration and cooperation.

I the patient acknowledge I have read and fully understand the above policies and that I agree with the policies and fees. All of my questions have been answered.

_____ _____

Signature of patient or person authorized to consent Date