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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 _____ Social Security # _____

Marital Status _____ Referred by _____

Emergency Contact: Name_____ Relationship _____Phone _____

Primary Care Physician: Name _____ Phone _____

Other Practitioners Involved In Your Care:

Name _____ Phone _____

Name _____ Phone _____

Insurance:
Primary Insurance Company _____ Plan_____

Policy/ID # _____ Group #_____

Who is the holder for your primary insurance? ☐Self ☐Spouse ☐Child ☐Other_____

If you are *not* the policy holder, please complete:

Policy Holder Name: _____ Policy Holder Gender_____

Date of Birth: _____ Social Security Number: _____

Secondary Insurance Company _____ Plan_____

Policy/ID#_____ Group#_____

Secondary Policy Holder Name: _____

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 24 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):

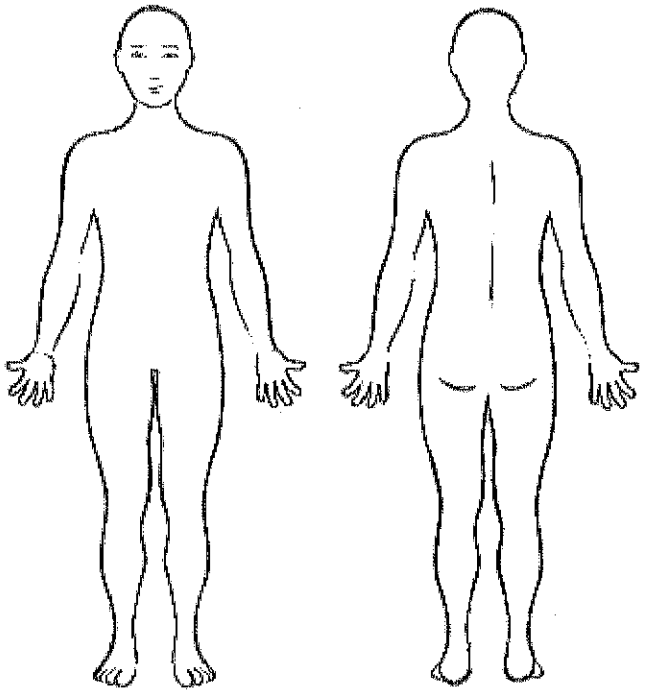
_____

_____

_____

_____

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	☐	☐	loss of appetite	☐	☐
weight loss/gain	☐	☐	increase in appetite	☐	☐
brain fog or confusion	☐	☐	trouble falling asleep	☐	☐
dizziness/vertigo	☐	☐	trouble staying asleep	☐	☐
fatigue during the day	☐	☐	swollen/sore lymph nodes	☐	☐
fevers	☐	☐	bleed or bruise easily	☐	☐
chills	☐	☐	autoimmune disease	☐	☐

Please elaborate:

Skin & Hair

	past	current		past	current
rashes/hives	☐	☐	psoriasis	☐	☐
eczema	☐	☐	itchy skin	☐	☐
dry skin	☐	☐	acne	☐	☐
oily skin	☐	☐	loss of hair/thinning hair	☐	☐

Please elaborate:

Head, Ears, Eyes, Nose & Throat

	past	current		past	current
earaches/pressure in the ears	☐	☐	headaches/migraines	☐	☐
ringing in the ears	☐	☐	sinus pressure	☐	☐
hearing loss	☐	☐	nose bleeds	☐	☐
eye floaters	☐	☐	dizziness/vertigo	☐	☐
itchy eyes	☐	☐	teeth/jaw clenching	☐	☐
blurry vision	☐	☐	sore throat	☐	☐
vision loss	☐	☐	swollen throat	☐	☐

Please elaborate:

_____

_____

_____

Cardiovascular/Circulatory

	past	current		past	current
chest pain	☐	☐	swelling/edema	☐	☐
fainting	☐	☐	high blood pressure	☐	☐
lightheadedness	☐	☐	low blood pressure	☐	☐
cold hands & feet	☐	☐	palpitations	☐	☐
heart arrhythmia	☐	☐	heart murmur	☐	☐
shortness of breath	☐	☐			

Please elaborate:

_____

_____

_____

Respiratory

	past	current		past	current
pain on inhaling	☐	☐	sneezing	☐	☐
chest tightness	☐	☐	seasonal/other allergies	☐	☐
cough	☐	☐	phlegm production	☐	☐

asthma	☐	☐	nasal congestion	☐	☐
wheezing	☐	☐	difficulty swallowing	☐	☐
pain behind the eyes	☐	☐			

Please elaborate:

Genito-Urinary

	past	**current**		**past**	**current**
difficulty urinating	☐	☐	urgent/frequent urination	☐	☐
blood in urine	☐	☐	sores on genitals	☐	☐
pain upon urination	☐	☐	genital pain	☐	☐
STD	☐	☐	yeast infections	☐	☐
bacterial vaginosis	☐	☐			

Please elaborate:

Neurological/Psychological

	past	**current**		**past**	**current**
anxiety	☐	☐	poor memory	☐	☐
depression	☐	☐	quick temper	☐	☐
loss of balance/coordination	☐	☐	easily susceptible to stress	☐	☐
areas of numbness/paralysis	☐	☐	mood swings	☐	☐
irritability	☐	☐	ADD/ADHD	☐	☐
Parkinson's	☐	☐	Multiple Sclerosis	☐	☐

Please elaborate:

Digestive

	past	current		past	current
heartburn	☐	☐	gas	☐	☐
belching	☐	☐	diarrhea	☐	☐
bloating	☐	☐	constipation	☐	☐
nausea	☐	☐	abdominal pain/cramps	☐	☐
vomiting	☐	☐	mucus in stool	☐	☐
chronic bad breath	☐	☐	blood in stool	☐	☐
sores on lips/tongue	☐	☐	hemorrhoids	☐	☐

Please elaborate:

_____

_____

For Women Only:

	past	current		past	current
irregular periods	☐	☐	breast pain	☐	☐
painful periods	☐	☐	vaginal discharge	☐	☐
bleeding between periods	☐	☐	vaginal sores	☐	☐
period clots	☐	☐	hot flashes	☐	☐
menstrual cramping	☐	☐	night sweating	☐	☐

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:

For Men Only:

	past	current		past	current
erectile dysfunction/impotence	☐	☐	ejaculatory pain	☐	☐
varicocele	☐	☐	BPH	☐	☐

Please elaborate:

Lifestyle:

Current medications/herbs/supplements (please list name, dosage, and frequency):

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

How much water do you drink per day?

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 drink alcohol? If so, how many drinks/week?

Do you or have you ever used recreational drugs? If so, what, and 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.