

## New Patient Information

Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Street Address \_\_\_\_\_ Apt. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Preferred Phone \_\_\_\_\_ Email \_\_\_\_\_  
Birth Date (include year) \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Referred by \_\_\_\_\_

Emergency Contact: 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 # \_\_\_\_\_

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 do so with 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

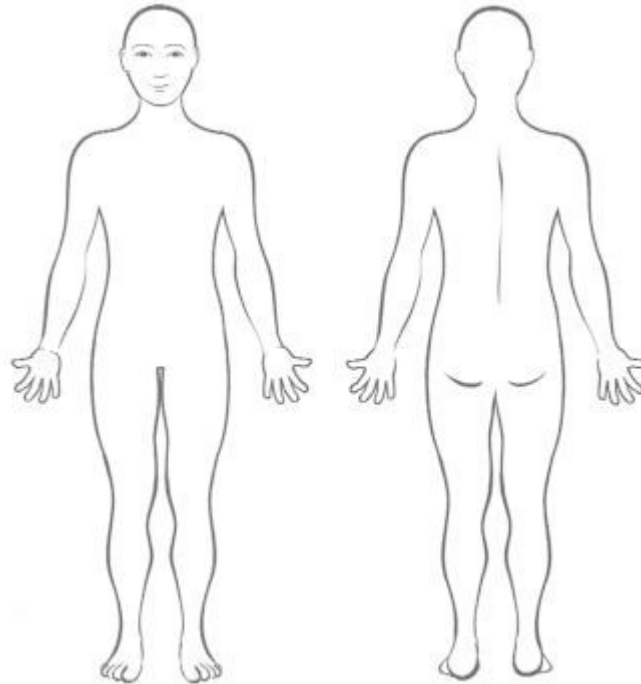
## Health History

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

Main issue(s) you are seeking treatment for: \_\_\_\_\_

Diagnosis from a medical professional (if applicable): \_\_\_\_\_

**Please mark any areas of pain or discomfort:**



**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"/>	fatigue	<input type="checkbox"/>	<input type="checkbox"/>
night sweating	<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"/>
change in appetite	<input type="checkbox"/>	<input type="checkbox"/>	weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>
dizziness/vertigo	<input type="checkbox"/>	<input type="checkbox"/>	poor sleep	<input type="checkbox"/>	<input type="checkbox"/>

### 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"/>	loss of hair	<input type="checkbox"/>	<input type="checkbox"/>
acne	<input type="checkbox"/>	<input type="checkbox"/>			

## 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"/>			

## 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"/>			

## 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"/>			

## 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"/>

## 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"/>

	past	current		past	current
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"/>			

**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"/>

**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 \_\_\_\_\_

Have you been through menopause? Age? \_\_\_\_\_

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.)

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**For Men Only:**

	<b>past</b>	<b>current</b>		<b>past</b>	<b>current</b>
erectile dysfunction/impotence	<input type="checkbox"/>	<input type="checkbox"/>	ejaculatory pain	<input type="checkbox"/>	<input type="checkbox"/>
varicocele	<input type="checkbox"/>	<input type="checkbox"/>	BPH	<input type="checkbox"/>	<input type="checkbox"/>

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**Lifestyle**

Current medications/herbs/supplements:

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

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Current exercise routine:

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Do you use tobacco? If so, how often?

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

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Are you currently taking any of the following medications?

*(circle if yes and indicate how often)*

Advil/Motrin/Ibuprofen

Aleve/Naproxen

Bayer/Aspirin

Celebrex/Celecoxib

Prednisone/Prednisolone

Are you currently taking any other pain medications? If yes, list name and amounts per day:

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

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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:

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**Family Medical History**

Cancer     Seizures     High blood pressure     Stroke     Diabetes  
 Heart Attack     Hepatitis     Asthma     Other \_\_\_\_\_

**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.*