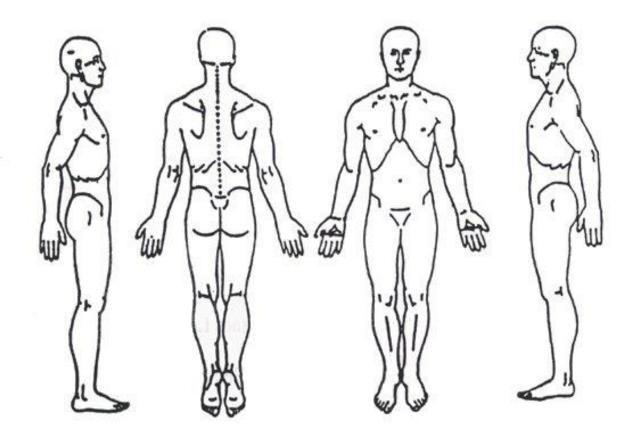


## Acupuncture Intake and History Forms

Patient Name:		Cell Phone:	Carrier:
Address:		City:	State: Zip:
Date of Birth:	Age:	Home Phone:	Preferred Contact: Home or Ce
Email:		How were you referred to	the office?
Name and Phone Numbe	r of Primary Care Ph	ysician:	
Emergency Contact:			_Phone:
Have you had acupunctur	e before? YES N	IO If so, Where and what was	s outcome?
Main Complaint			
Please list your complaint	s or health goals with	n Acupuncture:	
When and how did the co	mplaint begin?		
On a scale of 0 to 10, how	v severe are your syr	mptoms? (0 being none, 10 be	eing very severe)
What makes it worse?			
What makes it better?			
□What diagnosis have yo	ou been given for the	se problems?	
□What other treatments h	nave you tried and wh	nat were the outcomes?	
Personal History			
Illnesses/Current Hea	alth Issues		
Major Surgeries			

Significant Trauma: (i.e.
motor vehicle accidents,
fractures, etc.)
Do have a history of current or
past infectious disease? Please
describe
Medicines (please list all
medications, herbs, vitamins
and over the counter drugs)
Allergies/Sensitivities (Please list
any foods, drugs, medications or
environmental factors which you
are sensitive or allergic to)

## Please describe pain and place on diagram below:



## Please place a check below if you have had symptoms within the last six (6) months: *General*

Door Appotito	□ Maskness	Cuddon Enorgy Drone
Poor Appetite	Weakness	Sudden Energy Drops
Hearing Loss	☐ Fevers	Chills
Easy to Bleed or Bruise	Sweat Easily	☐ Fatigue
Strong Thirst	Poor Sleep	☐ Tremors
Puffiness or Swelling	Poor Balance	Weight Loss
Night Sweats	Cravings	Weight Gain
☐ Changes in Appetite	Other:	

Pleas	•	hav	e had symptoms within the la	st s	ix (6) months:
	Rashes		l Itching		l Dandruff
			l Eczema		
					Recent Moles
Head,	Eyes, Ears, Nose, and Throat				
			l Toothache		Blurry Vision
	Cataracts		l Ear Ringing		Sinus Problems
	Taste/Smell Problems		l Headaches		Concussions
	Eye Strain/Pain		Night Blindness		Poor Hearing
	•		l Facial Pain		TMJ Pain
	Migraines		l Ear Aches		Spots in Front of Eyes
			Lip or Tongue Sores		. :
Cardi	ovascular				
	High Blood Pressure		Low Blood Pressure		Irregular Heartbeat
	Cold Hands or Feet		Blood Clots		Palpitations
	Swelling of Hands		Swelling of Feet		Chest Pain
	Phlebitis		Fainting		Lightheadedness
_	THESICIS		Tunting		Lightmeddedness
Respire	atory				
	Cough		Bronchitis		Difficulty Breathing
	Phlegm		Coughing Up Blood		Pneumonia
	Asthma		Painful Breathing		Easily Winded
Gastro	-Intestinal				
	Nausea		Constipation		Diarrhea
	Bad Breath		Ulcers		Abdominal Pain
	Chronic Laxative Use		Vomiting		Intestinal Gas
	Indigestion		Rectal Pain		Belching
	Blood in Stools		Hemorrhoids		J
Urolog	v				
_	Painful Urination		Urgency to Urinate		Unable to Hold Urine
	Decrease in Urine Flow		Frequent Urination	_	Blood in Urine
	Cloudy Urine		Kidney Stones		Frequent Night Urination
	Pain in Groin Area		Sexually Transmitted		Trequent Hight of mation
_			Disease		
Neuro-	Psychological				
	Seizures		Areas of Numbness		Concussion
	Twitches		Lack of Coordination		Depression
	Irritability		Loss of Balance		Stress
	Poor Memory		Anxiety		Mood Swings
	Tremors	_	,	_	

Age of Menses	Please place a check below if yo	ou ha	ve had symptoms withir	the last s	six (6) months:
Duration of Menses	Gynecology				
Date of Last Menses	Age of Menses		Irregular Periods		Clots
# of Pregnancies   Spotting   Yeast Infections   Wasculo-Skeletal   Arthritis   Muscle Weakness   Muscle Cramping   Weak Joints   Muscle Spasms   Scollosis   Weak Joints   Weak Joints   Pain with Weather   Changes   Pain with Activity   Pain After Waking   Do you currently have an exercise regimen?   If so, please describe:   Pain After Waking   Do you drink coffee?   How much?   Po you drink coffee?   How much?   Po you drink alcohol?   How often?   How often?   If so, how often and how are your currently managing it?   I certify the information provided is accurate to the best of my knowledge:   Signature of Patient   Date:   Da			Painful Periods		PMS
# of Births	Date of Last Menses		Breast Lumps		Menopausal
Muscle Skeletal Arthritis   Muscle Weakness   Muscle Cramping   Muscle Spasms   Scoliosis   Weak Joints   Pain with Weather   Pain with Activity   Pain After Waking   Do you currently have an exercise regimen?   If so, please describe:   Do you drink coffee?   How much?   Do you drink alcohol?   How much?   Do you drink alcohol?   How often?   Are you under regular stress?   If so, how often and how are your currently managing it?   I certify the information provided is accurate to the best of my knowledge: Signature of Patient   Date:    AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of care, regardless of insurance coverage, I also understand that If suppended to care as determined by my treating doctor, any fees for professional services will be immediately due and payable. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone (other than the parties mentioned above) that you do want to receive your medical records, please inform our office.	# of Pregnancies		Spotting		Yeast Infections
Arthritis	# of Births		Vaginal Discharge		Fertility Problems
Muscle Spasms	Musculo-Skeletal				
Pain with Weather Changes	Arthritis		Muscle Weakness		Muscle Cramping
Changes	Muscle Spasms		Scoliosis		Weak Joints
Do you drink coffee? How much?  Do you drink coffee? How much?  Do you drink alcohol? How often?  Are you under regular stress? If so, how often and how are your currently managing it?  I certify the information provided is accurate to the best of my knowledge:  Signature of Patient Date:  AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone (other than the parties mentioned above) that you do want to receive your medical records, please inform our office.  Patient's Signature:	Pain with Weather				
Do you drink coffee? How much?	Changes		Pain with Activity		Pain After Waking
Current tobacco use? How much?	Do you currently have an exercise regime	en?	If so, please	describe: _	
Are you under regular stress? If so, how often and how are your currently managing it? I certify the information provided is accurate to the best of my knowledge:    Certify the information provided is accurate to the best of my knowledge:	Do you drink coffee? How	much	?		
Are you under regular stress? If so, how often and how are your currently managing it? I certify the information provided is accurate to the best of my knowledge:  Signature of Patient Date:	Current tobacco use? How	v mucl	า?		
Are you under regular stress? If so, how often and how are your currently managing it? I certify the information provided is accurate to the best of my knowledge:  Signature of Patient Date:	Do you drink alcohol? Ho	w ofte	n?		
I certify the information provided is accurate to the best of my knowledge:  Signature of Patient					1
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Guardian's Signature Authorizing Care:	chiropractic office. I authorize the doctor of physicians and other healthcare providers responsible for all costs of care, regardles my schedule of care as determined by my and payable. The patient understands an Information for the purpose of treatment, know how your Patient Health Information records. If you would like to have a more your Patient Health Information we encoudesk before signing this consent. If there receive your medical records, please info	to releaded so rel	ase all information necessary bayers and to secure the payers and to secure the payers are coverage. I also uning doctor, any fees for professes to allow this chiropractic cent, healthcare operations, a ing to be used in this office and account of our policies and you to read the HIPAA NOTION (other than the parties of the office.	y to commu yment of be derstand the essional ser- office to use and coordinal and your rigled d procedure CE that is a mentioned all	nicate with personal nefits. I understand that I am at if I suspend or terminate vices will be immediately due their Patient Health tion of care. We want you to nts concerning those es concerning the privacy of vailable to you at the front bove) that you do want to
Parameter and the state of the	Guardian's Signature Authorizing Care:			[	Date: