

Acupuncture and Healing Arts Medical Group
Clark Tower, 3rd Floor 5100 Poplar Ave, Suite 318 Memphis TN 38137

Notice of Privacy Practices Acknowledgement

A record of the health care services that we provide to you is used and disclosed by this office when providing you with treatment, collecting payments for treatment provided to you and in other health care operations.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, our obligations in protecting your health information and your rights regarding the information contained in your medical record.

We will not use or disclose the information contained in your record in any way that is inconsistent with the policies detailed in our current Notice of Privacy Practices.

If you have questions or would like additional information about this notice, please notify our office.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Signature of patient or legally authorized individual

Date

Time

Printed name if signed on behalf of patient

Relationship to patient (parent, legal guardian, etc.)

This form will be retained in your medical record.

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Informed Consent for Treatment

Traditional Chinese Medicine includes various modalities such as acupuncture, herbology, tuina, massage cupping, guasha, moxibustion, acupressure, warming, and other types of hands-on healing, as well as electric stimulation to filaments and infrared cold laser. These ancient oriental techniques utilize a natural system of healing within the body.

I, the undersigned, hereby authorize the licensed staff of the Acupuncture & Healing Arts Medical Group to perform the above listed modalities, including acupuncture procedures induced by the insertion of sterile, single-use needles/filaments into the underlying tissues at certain indicated points on the surface of the body. The nature, consequences, and potential risks and benefits of these procedures have been explained to me.

POTENTIAL RISKS: Discomfort at the insertion site of the needle, bruising, weakness, fainting, nausea, and possible short term aggravation of symptoms existing prior to acupuncture treatment.

POTENTIAL BENEFITS: To allow for drugless relief of presenting symptoms and improved balance of bodily energies which may lead to prevention or elimination of the presenting problem.

With this knowledge, I voluntarily consent to the above procedures. I understand these techniques are not a substitute for conventional medical care. I realize that no guarantees have been given to me regarding cure or improvement of my condition and that no treatment program is effective for everyone.

I understand that I am free to discontinue my treatment at any time. I also understand that my medical and/or clinical records will be kept confidential and only disclosed with my permission or summarized anonymously. (initial _____)

I hereby authorize the licensed staff of the Acupuncture and Healing Arts Medical Group to verify my history or condition with my physician, if required, and to release my medical records to my insurance company if they so require in order to honor my insurance claim.

Payment is due at the time services are rendered. First appointment fees are \$140 for adult acupuncture (over the age of 15), \$50 for pediatric (under the age of 15), and \$50 for herbal consultation. Follow up appointment fees are \$75 for adult acupuncture (over the age of 15), \$40 for pediatric (under the age of 15), and either \$50 or \$25 for herbal consultation, depending on the length of the visit. Herbal preparations are additional.

We require 24 hour notice given to change or cancel your appointment. We understand emergency situations but otherwise you will be charged for the missed visit. **Please do not wear colognes, perfumes, or scented lotions to the office.**

Welcome as a new client. We greatly appreciate your cooperation and look forward to treating you.

Print Patient Name _____ Date _____

Patient/Guardian Signature _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
- Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help you with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our offices to recommend treatment alternatives or to provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, of health care operations...or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive it electronically

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice of Privacy Practices from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPAA: The U.S Department of Health toll free 877-696-6775
Office of Civil Rights: 200
Washington, D.C. 20201

Acupuncture & Healing Arts Medical Group

Name _____

Allergies _____

List all medicines, herbs, remedies, and supplements used in the last 2 months.

Medicine/herb/supplement Name	Dose	Frequency

List all Doctors and Therapists you have seen in the last 2 years.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Musculoskeletal

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Fractures/broken bones | <input type="checkbox"/> Joints make noise | <input type="checkbox"/> Back pain | <input type="checkbox"/> Intermittent pain |
| <input type="checkbox"/> Muscle spasms, cramps, tension | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> o Upper | <input type="checkbox"/> Constant pain |
| <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Whiplash | <input type="checkbox"/> o Mid | <input type="checkbox"/> Weak muscles |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Bone pain | <input type="checkbox"/> Pain down legs | <input type="checkbox"/> o Lower | <input type="checkbox"/> Other spinal problems |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Bone problems | <input type="checkbox"/> Numbness, tingling | |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Gout | <input type="checkbox"/> Trembling, tremors | <input type="checkbox"/> Disc problems | |

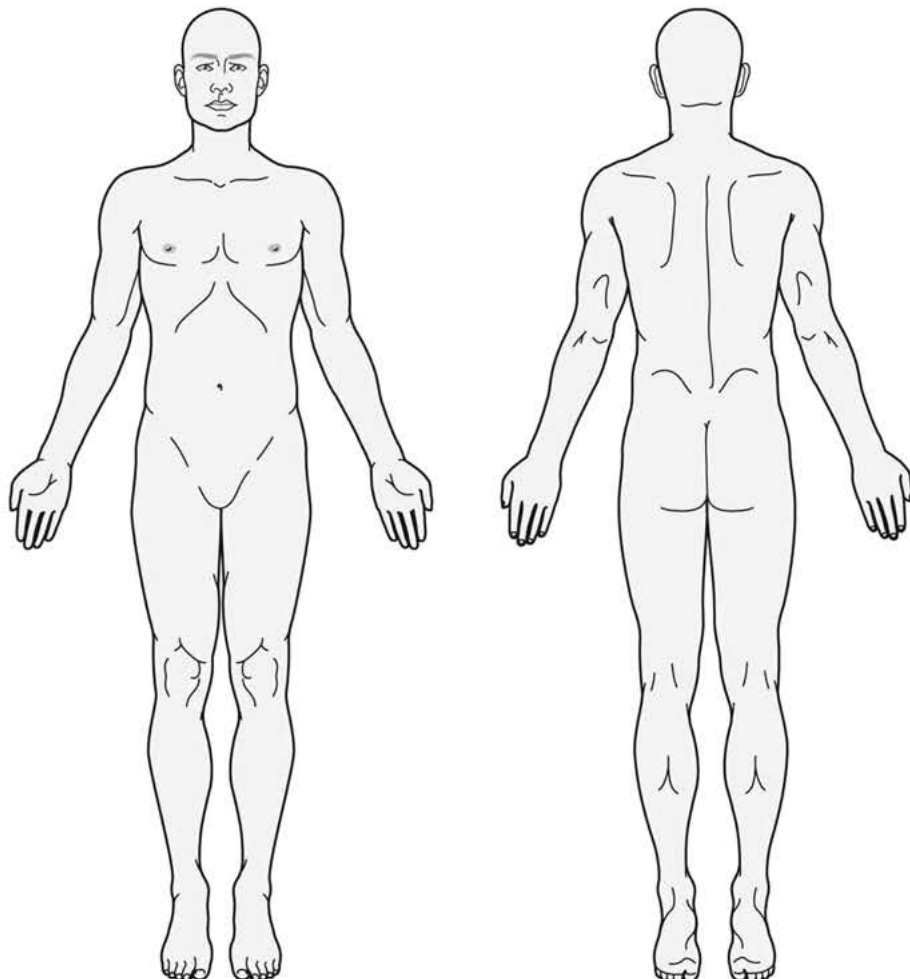
No pain Mildly Annoying Nagging, uncomfortable Distressing, miserable Intense, horrible Worst possible, unbearable
 Current level of pain 0 1 2 3 4 5 6 7 8 9 10

Are you physically active on a regular basis? yes / no Type of exercise: _____ How long: _____ How often: _____

Neuro/Emotional/Psychological

- | | | | | |
|--|---|---|--|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Unusual fears | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Disorientation | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Forgetful | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Pessimistic |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Agitation | <input type="checkbox"/> Considered suicide | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Optimistic |
| <input type="checkbox"/> Worry a lot | <input type="checkbox"/> Decisions difficult | <input type="checkbox"/> Treated for emotional problems | <input type="checkbox"/> Inability to focus on tasks | <input type="checkbox"/> Perfectionist |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lose temper easily | <input type="checkbox"/> Repeated thoughts | <input type="checkbox"/> Hold a grudge | <input type="checkbox"/> Motivation low |
| <input type="checkbox"/> Anxious/nervous | <input type="checkbox"/> Easily stressed | | <input type="checkbox"/> Fearful | <input type="checkbox"/> Motivation normal |
| <input type="checkbox"/> Feel overwhelmed | <input type="checkbox"/> Feel unhappy | | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Motivation high |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Work/family problems | | <input type="checkbox"/> Dull thinking | |
| | | | <input type="checkbox"/> Stroke | |

Please use the diagram to indicate where you feel pain or symptoms



Respiratory

- | | | | | |
|--|--|---|---|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> TB | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Excessive phlegm | <input type="checkbox"/> Difficulty breathing when lying down |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Tight chest | <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Whooping cough | <input type="checkbox"/> How many pillows used? ____ |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Wheezing or gasping | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dry cough | <input type="checkbox"/> Emphysema | | |
-

Gastrointestinal

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Sweet taste in mouth | <input type="checkbox"/> Bloody stools | <input type="checkbox"/> Recent weight loss/gain |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> IBS | <input type="checkbox"/> Gall bladder problems | <input type="checkbox"/> Black stools | <input type="checkbox"/> Laxative use |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Intestinal gurgling | <input type="checkbox"/> Fecal incontinence |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Colitis | <input type="checkbox"/> Colon problems | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Food sits in stomach | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Stomachache | <input type="checkbox"/> ST problems | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Bitter taste in mouth | <input type="checkbox"/> Constipation | <input type="checkbox"/> Pain/cramps | <input type="checkbox"/> Bowel frequency | |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Diarrhea/loose stool | <input type="checkbox"/> Rectal pain/itch | <input type="checkbox"/> Hemorrhoids | |
| | | | <input type="checkbox"/> Number of daily BMs ____ | |
-

Genitourinary

- | | | | | |
|--|--|---|---|--|
| <input type="checkbox"/> Burning/pain with urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Dribble urine with sneeze | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Painful sex |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Weakened urine stream | <input type="checkbox"/> Difficulty or slow starting stream | <input type="checkbox"/> VD | <input type="checkbox"/> Change in sexual energy |
| <input type="checkbox"/> Wake up to urinate | <input type="checkbox"/> Cloudy urine | <input type="checkbox"/> Kidney infections | <input type="checkbox"/> Herpes | <input type="checkbox"/> Infertility |
| | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Flank pain | <input type="checkbox"/> Bedwetting |
| | | | <input type="checkbox"/> Urgency to urinate | |
-

Women

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> Vaginal burning/itching | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Last mammogram | <input type="checkbox"/> Breast tenderness/pain | <input type="checkbox"/> Change in body/psych prior to menstruation |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Vaginal infections | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Breast discharge | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Yeast | <input type="checkbox"/> Last menstrual period | <input type="checkbox"/> Water retention | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> HRT |
| <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Number of births | <input type="checkbox"/> Abortions | <input type="checkbox"/> Menopausal | <input type="checkbox"/> PID |
| <input type="checkbox"/> Itch | <input type="checkbox"/> Premature births | <input type="checkbox"/> Sexually active | <input type="checkbox"/> Other surgeries | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Vaginal bleeding between periods | <input type="checkbox"/> Miscarriages | <input type="checkbox"/> Irregular menses | <input type="checkbox"/> Sexual drive increased | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Number of pregnancies | <input type="checkbox"/> Age of first menses | <input type="checkbox"/> Clots | <input type="checkbox"/> Sexual drive depressed | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Duration of periods | <input type="checkbox"/> Painful menses | <input type="checkbox"/> PMS | <input type="checkbox"/> Children (names/ages) |
| <input type="checkbox"/> Change in flow | <input type="checkbox"/> Last Pap | <input type="checkbox"/> Birth control | | |
| | | <input type="checkbox"/> Now pregnant | | |
| | | <input type="checkbox"/> Breast lumps | | |
-

Describe your usual flow

Men

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> Testicular pain | <input type="checkbox"/> Prostate enlargement | <input type="checkbox"/> Nocturnal emissions | <input type="checkbox"/> Loss of semen during the day | <input type="checkbox"/> Sexual drive increased |
| <input type="checkbox"/> Penile pain | <input type="checkbox"/> Hernia | <input type="checkbox"/> Herpes | <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Sexual drive depressed |
| <input type="checkbox"/> Genital itch | <input type="checkbox"/> Loss of erection, impotence | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Children (names/ages) |
| <input type="checkbox"/> Sexually active | | <input type="checkbox"/> Prostatitis | | |
-

Physical Symptoms

Please check all symptoms you have experienced during the past 6 months. Circle those that have been the most troublesome.

General

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Poor Endurance | <input type="checkbox"/> Gnawing hunger | <input type="checkbox"/> Lack of perspiration | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Sleep (Avg ____ hrs) | <input type="checkbox"/> Food cravings | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Aversion to talking |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Peculiar tastes/smells | <input type="checkbox"/> Sudden energy drop @ ____ time | <input type="checkbox"/> Strong thirst cold/hot drinks |
| <input type="checkbox"/> Wakens easily | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Bleed or bruise easily (where? _____) |
| <input type="checkbox"/> Unable to fall asleep | <input type="checkbox"/> Obesity | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Cuts bleed excessively |
| <input type="checkbox"/> Heavy Sleep | <input type="checkbox"/> Recent weight loss/gain | <input type="checkbox"/> Chills easily | <input type="checkbox"/> Takes afternoon rests/naps |
| <input type="checkbox"/> Unable to stay asleep | <input type="checkbox"/> Tire easily | <input type="checkbox"/> Low fever, late afternoon or evening | <input type="checkbox"/> Most energized in the am |
| <input type="checkbox"/> Dream disturbed sleep | <input type="checkbox"/> Fevers | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Most energized in the pm |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Chills | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Prolonged recovery following illness |
| <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Cold back | <input type="checkbox"/> Poor coordination | |
| <input type="checkbox"/> Awaken fatigued | <input type="checkbox"/> Cold abdomen | <input type="checkbox"/> Jaundice | |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Excessive sweating | | |

Overall energy level: ☐ very high ☐ high ☐ medium ☐ low ☐ very low

Skin & Hair

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Hair/skin changes | <input type="checkbox"/> Boils | <input type="checkbox"/> Cracks | <input type="checkbox"/> Painful scars |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples/boils | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Shingles | <input type="checkbox"/> Lumps or bumps |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Purpura | <input type="checkbox"/> Itching | <input type="checkbox"/> Dry hair/skin | <input type="checkbox"/> Pasty/pale complexion |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Warts/growths | <input type="checkbox"/> Fungal infections | <input type="checkbox"/> Brittle hair | <input type="checkbox"/> Other hair/skin problems |
| <input type="checkbox"/> Fingernail problems | <input type="checkbox"/> Hives | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Limp hair | |
-
-

Head

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Eyes watering | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Teeth hurt | <input type="checkbox"/> Recurrent sore throat |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Double vision | <input type="checkbox"/> Mucus | <input type="checkbox"/> Sore/bleeding gums | <input type="checkbox"/> Grinds teeth |
| <input type="checkbox"/> Migraines
When? _____
Where? _____ | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Ear drainage | <input type="checkbox"/> Bad taste in mouth | <input type="checkbox"/> Sore tongue |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Hoarse voice | <input type="checkbox"/> Dry throat | <input type="checkbox"/> Facial pain/tics |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Excess saliva |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Stuffy/runny nose |
| <input type="checkbox"/> Color blindness | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Eye pain/itch | <input type="checkbox"/> Ringing in ears (pressure in eyes) | <input type="checkbox"/> Mouth/lip sores | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Sinus pressure |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Jaw clicks | <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Sinus congestion |
| <input type="checkbox"/> Spots in eyes/floaters | <input type="checkbox"/> Frequent head colds | <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Glasses | <input type="checkbox"/> Post nasal drip |
| | <input type="checkbox"/> Earaches | <input type="checkbox"/> Sneezing spells | | |
| | | <input type="checkbox"/> Teeth problems | | |
| | | <input type="checkbox"/> Loss of teeth | | |
-
-

Cardiovascular

- | | | | | |
|--|---|---|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rapid heart beat | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Swelling in hands/feet | <input type="checkbox"/> Skipped heartbeats |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Phlebitis (inflamed veins) |
| <input type="checkbox"/> Chest pain/pressure | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Fainting | <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Mitral valve prolapse |
| | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Raynaud's disease | |
| | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Vascular spiders | | |
| | | <input type="checkbox"/> Leg cramps | | |
-
-

ACUPUNCTURE & HEALING ARTS MEDICAL GROUPwww.acupuncturememphis.comClark Tower 3rd Floor
5100 Poplar Ave, Suite 318
Memphis, TN 38137

901-763-0909

fax: 901-763-4060

Patient Intake Form

Date: _____

Last Name		First Name	Middle Initial	Male/Female	Date of Birth	Marital Status	Are you pregnant?
Street Address				Home Phone		Work Phone	
City		State	Zip	Cell Phone		E-mail	
Occupation				Employer		Have you had acupuncture? Y N	
Primary Physician		Last date MD consulted		Emergency contact name		Referred by: Emergency contact phone number	

What is your present complaint/concern?

_____**Significant Past Illnesses**

- | | | | | |
|--|--------------------------------------|----------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV+ | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> CFS/EBS | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Stroke | <input type="checkbox"/> Measles | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Meniere's | <input type="checkbox"/> Mumps | <input type="checkbox"/> Mono | <input type="checkbox"/> Polio |

Other Illnesses: _____

Surgeries (include procedure and date)

_____**Significant Traumas** (include auto accidents, falls, broken bones, etc.)

_____**Family Medical History**Please indicate Mother, Father, Sister, or Brother

- | | | | | | |
|--|---------|---|---------|--|---------|
| <input type="checkbox"/> Diabetes | M F S B | <input type="checkbox"/> Alcoholism | M F S B | <input type="checkbox"/> Seizures | M F S B |
| <input type="checkbox"/> Asthma | M F S B | <input type="checkbox"/> Mental Illness | M F S B | <input type="checkbox"/> Emphysema | M F S B |
| <input type="checkbox"/> Arthritis | M F S B | <input type="checkbox"/> Stroke | M F S B | <input type="checkbox"/> High Blood Pressure | M F S B |
| <input type="checkbox"/> Allergies | M F S B | <input type="checkbox"/> Obesity | M F S B | <input type="checkbox"/> Other _____ | M F S B |
| <input type="checkbox"/> Heart Disease | M F S B | <input type="checkbox"/> Thyroid Problems | M F S B | | |

Habits

- | | | | | |
|-------------------------------------|-------------------------------|----------------------------------|--------------------------------|--------------------------------------|
| <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Tea | <input type="checkbox"/> Drugs | <input type="checkbox"/> Sugar | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Coffee | <input type="checkbox"/> Cola | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Salt | |

Do you have any infectious diseases? **Y** **N** If yes, please identify _____

Height: _____ Weight: Currently _____ Past Maximum _____ When? _____

Blood Pressure: What is your most recent blood pressure reading? _____ / _____

When was this reading taken? _____