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NEW PATIENT INFORMATION

NAME _____ Date _____

Address _____

City _____ State _____ Zip _____

Day Phone #_____ Evening Phone # _____

Cell Phone #_____ E-mail Address _____

Date of Birth _____ Age ____ Sex ____ Height ____ Weight _____

Referred by _____ Phone # _____

EMPLOYER _____ Phone # _____

Address _____

City _____ State _____ Zip _____

Occupation _____ How long _____

Name of Spouse _____

Number of Children: Boys _____ Ages _____ Girls _____ Ages _____

In case of emergency, contact: _____

Address _____

City _____ State _____ Zip _____

Day Phone _____ Evening Phone _____

Cell Phone _____ E-mail Address _____

My insurance company covers acupuncture treatment. Yes No (If yes, fill in Ins. Info)

Insurance Company _____ Phone # (____) _____

Address _____

City _____ State _____ Zip _____

ID # _____ Group # _____

Name of insured _____

Social Security # of Insured _____

PATIENT HEALTH QUESTIONNAIRE

Present Health Complaint(s) Indicate Treatment & Results

1_____

2_____

3_____

4_____

When were you last seen by a physician? _____

For what purpose? _____

Doctor's name _____ Specialty _____

Address _____

City _____ State____ Zip _____ Phone # _____

Diagnosis by your doctor: _____

List lab work completed:

_____

_____

List current medications: Indicate response to medication

1._____ _____

2._____ _____

3,_____ _____

4. _____ _____

Current supplements or over-the-counter items Indicate response to supplements

1._____ _____

2._____ _____

3,_____ _____

4._____ _____

Circle the items that you use? Indicate how much and how often?
Coffee _____
Tea _____
Alcohol _____
Chocolate _____
Cigarettes _____
Laxatives _____
Sugar _____
Artificial Sweeteners _____

List foods that you crave _____
_____

List known allergies to either food or drugs: _____
_____

Describe any special dietary restrictions: _____
_____
_____

Are you able to work without problems? If no, describe. _____
_____

How often do you feel fatigue? _____

What time of day are you the most tired? _____

Do you experience undue worry, difficulty concentrating or forgetfulness? If yes, describe.
_____

Have you had any significant accidents, injuries or illnesses? Describe: _____
_____

List any other hospitalizations or surgeries you have had, and your age at the time:
_____

Did you have any of the following childhood diseases?
Measles Mumps Chicken pox Frequent Ear Infections Rashes Mono

List any unusual childhood illnesses: _____
_____

Is your mother still alive? Yes No If not, age at death? _____

What was the cause of death? _____

Is your father still alive? Yes No If not, age at death? _____

What was the cause of death? _____

If any of your siblings have died, please give their ages and the cause of death: _____
_____

FAMILY HISTORY: Check all conditions that have affected your parents, grandparents, siblings & children

CONDITION	Relatives/s Affected	CONDITION	Relatives/s Affected
Addiction(s)	_____	Genetic Disease	_____
Allergies	_____	Gout	_____
Arthritis	_____	Headache/Migraine	_____
Asthma	_____	Heart Disease	_____
Bladder/Kidney	_____	High Blood Pressure	_____
Bleeding Issues	_____	Lung Issues	_____
Cancer	_____	Overweight	_____
Depression	_____	Stroke	_____
Diabetes	_____	Thyroid Disease	_____
Digestive	_____	Intestinal Issues	_____
Suicidal/Suicide	_____		

YOUR HISTORY: Check all of the conditions that you have now or ever have had.

__Alcoholism
__Arthritis
__Anxiety/Depression
__Autoimmune Disease
__Bladder/Kidney
__Cancer
__Digestive Issues
__Diabetes
__Ear Infections/Issues
__Eczema/Skin Issues
__Emphysema/Asthma
__Epilepsy/Seizures
__Eye Issues
__Genetic Condition
__Headaches
__Heart Disease
__High Blood Pressure
__HIV/AIDS
__Hormonal Issues
__Intestinal Issues
__Muscle Problems
__Neurological Issue
__Psychological Issues
__Respiratory Issues
__Rheumatic Fever
__Scarlet Fever
__Sexually Trans Dis.
__Sinus/Upper Resp.
__Stroke
__Swallowing Issues
Thyroid:Hypo__ Hyper__
__TMJ/Jaw Dysfunction
__Herpes __CMV
__Polio __Mono
__Weight Loss:
How much ___Time?____
__Weight Gain:
How much___ Time?____
__Other:_____
_____

ACTIVITY LEVEL:

__Sedentary (inactive) by choice
__Sedentary (inactive) due to inability or restriction
__Light: light daily work w/no regular exercise
__Moderate: light daily work and exercise 3X/week
__Sustained: moderate daily work & exercise 5X/week
__Sustained: moderate daily work & exercise 5X/week

STRESSES AFFECTING YOUR LIFE:

__Difficulties with work or lifestyle
__Recent change in marital status
__Death or serious illness of family or friend
__Dysfunctional family __Past __Present
__Lack of love or fulfilling relationship(s)
__Illness - self

How did you hear about me?_____