New Patient Information Form

Name _____Gender F ___M __
Date of Birth_____ /_____ /_____
Address _____
City_____ State____ Zip Code_____
Telephone:Home (_____)_____-_____
Cell (_____) _____-_____
Email _____
Marital Status: _____ Occupation:_____
Emergency Contact: _____ Phone: _____

Referred By: Yellow Page Website Newspaper Dr. Friend

Have you been treated by Acupuncture or Oriental medicine before? Yes OR No

Consent for Acupuncture
I, the undersigned, understand acupuncture treatment to involve the use of needles, acupressure, moxibustion and electrical stimulation etc. The risks, although limited, include: puncturing organs in the abdomen or chest cavities. Acupuncture may affect people on all levels: physical, emotional, mental and spiritual, because it works with the whole body to create balance. The duration of treatment varies from person to person depending on the specific illness and their constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or a series of treatments.

_____ _____/ _____ / _____
Patient's signature (Parent or Guardian if under 18) Date:

1. Main problem you would like us to help you with:

_____
2. How long ago did this problem begin?

_____
3. Have you been given a diagnosis for this problem? If so, what?

_____
4. What kinds of treatment have you tried?

_____
5. Are you currently receiving treatment for your problem? _____If so, please describe:
_____

6. Does anything improve your problem?

_____

PAST MEDICAL HISTORY
Do you have or had any of the following (Circle)

Cancer Heart Disease Hypertension Asthma Diabetes
Arthritis Lung Disease Stroke Multiple Sclerosis
Hepatitis HIV/Aids Stomach Trouble
Other Illnesses:
_____

Surgeries_____

Significant Trauma (Auto accidents, falls, etc.)
_____
Medicines (prescription and over-the-counter drugs, vitamins, herbs, etc. taken within the last three months)
_____
_____

Allergies:

FAMILY MEDICAL HISTORY (GENERAL HEALTH)

_____
_____

PERSONAL HISTORY
Please check if you have experienced any of the following in the last 3 months.

□ Fevers □ Chills □ Tremors □ Seizures □ Fainting □ Fatigue □ Night Sweats □ Day Sweating □ Poor Sleep/ Insomnia □ Poor Balance □ Headaches □ Dizziness □ Depression □ Emotional Changes □ Change in Appetite □ Peculiar tastes or smells □ Strong Thirst for Hot or Cold Drinks □ Weight Loss □ Weight Gain □ Bleeding or Bruising □ High blood pressure □ Low blood pressure □ Swelling of Hands or Feet □ Irregular heartbeat □ Palpitations □ Chest pain □ Difficulty in Breathing or Shortness of Breath □ Cold Hands/Feet□ Cough □ Pain w/ Deep Breaths □

Asthma □ Bronchitis □ Coughing Blood□ Production of phlegm What Color? _____□ Nausea □ Vomiting □ Belching □ Bad Breath □ Abdominal Pain/ Cramps □ Digestive Disorders □ Constipation □ Indigestion □ Diarrhea □ Blood in Stools□ Hemorrhoids□ Pain on Urination □ Urgent Urination □ Frequent Urination □ Decrease in Urine □ Blood in Urine □ Waking up to Urinate □ Impotency/ Infertility □ Genital Sores□ Muscular Weakness □ Muscular Atrophy □ Muscle Cramps □ Spasms □ Arthritis □ Recent Sprains □ Injuries or Falls □ General Aches □ Joint Instability

_____

Women Only

___Age at First Menses ___ First Date of Last Menstrual Cycle _____/_____/_____ ___Duration of Menses ____ Painful periods ____ Heavy periods____ Light periods
____ Irregular periods____ Clots____ Premenstrual irritability
____ Vaginal discharge____ On birth control ____ Fertility problems□____□Breast Lumps___ Number of Pregnancies ___ ___ Number of Births What type? _____ Miscarriages How long?_____

Notice of Privacy Practices (per HIPPA)

As your health care provider, we use your health information for evaluation and treatment, to obtain payment for treatment and to evaluate the quality of care that you receive. If you are referred to another health care provider, or at your request, your medical records may be shared with those providers via paper mail, electronic mail, fax, or other methods. We will ask your written permission to release your medical information in the form of a “Release of Medical Records” form. If you choose to sign such a form, you have the right to revoke that authorization at any time. We may, however, use your health care information without your authorization for the following reasons:

1. Public health safety
2. Auditing purposes
3. Emergencies
4. When required by law

If at any time, we change our policies in regard to your information, you will be informed with a new “Notice of Privacy Practices” and be asked to sign it.

You have the right to view and obtain a copy of your medical record. You also have the right to know to whom we have disclosed your medical records. If you believe the information in your record is not correct or missing information, you have the right to request that such information be corrected or added to your medical record. _____ Please initial here to indicate you have read and understand the above policy.