PATIENT INFORMATION

Name:_____ Sex: M F

Date of Birth:_____ Age:_____ Last 6 Digits of Social Security#_____

Address: _____ City: _____ State: ____

Zip: _____ Email: _____

Phone: Home:_____ Cell: _____ Work: _____

How did you learn of this clinic: [ ] Referral [ ] Phone Book [ ] Website [ ] Other _____

Who may we thank for your referral? _____

Occupation: _____

Name/Address of Employer: _____

Spouse/Significant Other: _____Phone: _____

Nearest relative not living with you: _____ Phone: _____

Relationship: _____ Address: _____

Family Physician: _____

State your Present Complaint, injury, or illness and give a brief account of its history and development (include dates): _____

_____

_____

Describe Previous Treatment of the foregoing described injury/illness and results: _____

_____

Is your condition due to an accident? Yes No If yes, date injury occurred:_____

Circle any other following illnesses you have or have had: Arthritis HIV PTSD Stroke Eye Disease Cancer Asthma Diabetes Heart Disease High Blood Pressure High Cholesterol Gall Bladder Disease Polio Kidney Disease Meningitis Rheumatic Fever Thyroid Disease Seizures Nervous Breakdown Venereal Disease Chronic Fatigue Syndrome Candida Yeast Other _____

Surgeries: _____

Allergies (food, drugs, chemicals): _____

Current Medications (include vitamins, herbs, drugs): _____

Do you use? (please circle): Cigarettes Tea Coffee Cola Alcohol Recreational Drugs

How much? _____ **Exercise**: _____

Family History: Has anyone in your immediate family ever had:: Cancer Tuberculosis Heart Disease High Blood Pressure Asthma Allergies Stroke Seizures Ulcers Arthritis Diabetes Kidney Disease Mental Disorder Glaucoma Thyroid Disease Other: _____

I understand and agree to receive acupuncture, injection therapy, recommendations for herbs or nutritional supplements.

I understand that all information that I provide is private and confidential. We will not disclose your record to others unless you direct us to do so in writing, or unless the law authorizes or compels us to do so.

I, the undersigned, understand that payment for service is expected at the time service is rendered. Missed appointments, without 24-hour prior notice, may be charged. I recognize that the provider cannot accept responsibility for collecting any insurance claim or negotiating any settlement on a disputed insurance claim. I also agree that in the even of default in the payment of any amount due, and if this account is placed in the hands of an agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection including agency and attorney fees and court costs incurred and permitted by the laws governing these transactions. A finance charge of 1.5 percent per month (annual rate of 18 percent) will be charged on all balances over 30 days, regardless of pending insurance claims.

Signature _____ Date _____

PATIENT INFORMATION (2)

Name: _____ Age: _____ M F Date: _____

Circle all of the following that describe your condition (Add comments where necessary)

-Headache Migraines Dizziness Vertigo

-Vision Problems Eye Dryness Spots in front of eyes

-Hearing loss Ringing or noises in ears Earaches

-Mouth sores Dental problems Gum problems Sore Throat

-Frequent Colds Poor sense of smell Hayfever Allergies Obstruction/Stuffiness

-Cough Asthma Shortness of Breath Wheezing Excess Sputum Color of Sputum

Chest Pain or Tightness Pain under Ribs Heart Palpatation's Irregular Heart Rate

Pain In: Neck Shoulder Arm Elbow Wrist/Hand Upper Back Hip

Pain In: Mid Back Low Back Leg Knee Foot Muscular Joint Weakness

Heartburn Nausea Reflux Vomiting Indigestion Diarrhea Constipation Gas Bloating

Pain/Burning with Urination Frequent Urination Weak Urine Stream Night Urination

Incontinence or Dribbling Urine Cloudy Urine Dark Urine Pale Urine Difficulty Urinating

Incomplete Urination Frequent Bladder Infections Yeast Infections

Skin Rashes Sores Excess Perspiration Nightsweats Overheat Easily Cold Easy

Restlessness Anger Easily Cry Easily Frustrated Sad Depressed Anxious Fearful Happy

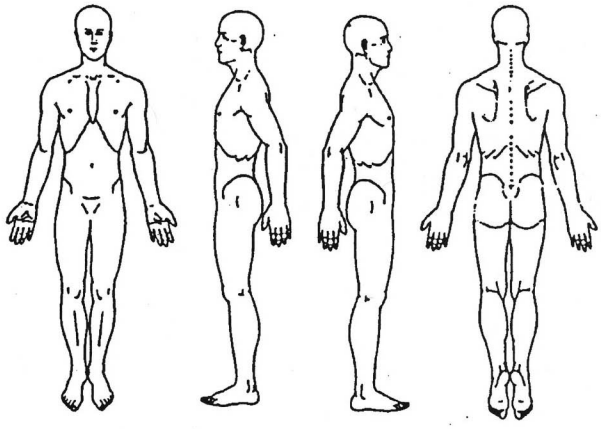
WOMEN: Irregular Menses PMS Cramps Clotting Endometriosis Infertility Menopause

MEN: Premature ejaculation Impotence Prostrate Problems

Please draw on the body diagrams showing the type of pain you feel today. Use the following symbols:

Dull Ache	X X X
Pins and needles	∇ ∇ ∇
Numbness	O O O
Burning	+ + +
Stabbing	◊ ◊ ◊
Other (specify)	* * *

_____



_____ _____

Signature Date