PATIENT INFORMATION

Harmony ACUPUNCTURE
Complimentary Alternative Medicine

Date _____

Name _____

Address _____

_____

City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate _____

☐ Single ☐ Married ☐ Significant Other

☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _____

Occupation _____

Employer _____

Emp. Address _____

Emp. Phone _____

Spouse/Partner's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse/Partner's Emp._____

Whom my we thank for referring you?

_____

PHONE NUMBERS

H _____ W _____ Cell _____

Best time/place to reach you _____

Email Address: _____

IN CASE OF EMERGENCY CONTACT

Name _____ Relationship _____

Home phone _____ Work phone _____

INSURANCE

Who is responsible for this account?_____

Relationship to Patient _____

Insurance Co._____

Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthday _____SS# _____

Relationship to Patient _____

Insurance Co._____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to _____ all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____

Relationship Date

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐Auto Insurance ☐Employer ☐Worker Comp ☐ Other

Attorney Name (if applicable) _____

GENERAL INFORMATION

Have you had acupuncture before? ☐ Yes ☐ No Have you used Chinese herbal medicine? ☐ Yes ☐ No

Are you currently under the care of physician? ☐ Yes ☐ No If yes, for what? _____

Physician's name _____ Phone _____

ORIENTAL MEDICINE INTAKE FORM

Name _____ Date _____

PRESENT HEALTH CONCERNS

1. _____ Approx. Date Of Onset _____
Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Other therapies tried ☐ Medications ☐ Surgery ☐ Chiropractic ☐ Phys. Therapy ☐ Other _____

2. _____ Approx. Date Of Onset _____
Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Other therapies tried ☐ Medications ☐ Surgery ☐ Chiropractic ☐ Phys. Therapy ☐ Other _____

3. _____ Approx. Date Of Onset _____
Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Other therapies tried ☐ Medications ☐ Surgery ☐ Chiropractic ☐ Phys. Therapy ☐ Other _____

Please list all **medications** that you are currently taking (or have used in the past two months), with dosages:

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

Please list any **vitamins, minerals or homeopathic remedies** that you are currently taking:

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

Please list all **allergies** that you have to any of the following:

Drugs _____ Foods _____

Other (i.e. pollen, paint, etc.) _____

HEALTH HISTORY

Past Medical History: Please list past injuries, broken bones, surgeries & hospitalizations, with approx dates:

_____

_____

_____

Personal Habits:

☐ Tobacco packs/day _____
☐ Alcohol drinks/wk _____
☐ Coffee/tea/cola cups/day _____
☐ Recreational drugs times/wk _____

☐ High Stress Level Reason _____

Do you follow any diet regimens/restrictions?
☐ Yes ☐ No If yes, describe

_____

_____

Work Activity:

☐ Sitting % of time _____
☐ Standing % of time _____
☐ Light labor % of time _____
☐ Heavy labor % of time _____

Exercise:
Do you exercise regularly? ☐ Yes ☐ No
If yes, describe & tell how often:

_____

_____

_____

FAMILY INFORMATION

Do you have children? ☐ Yes ☐ No If yes, how many? _____ Ages _____
Are you, or could you be currently pregnant? ☐ Yes ☐ No Due date _____

Please check if you have had (in the **last three months**)

GENERAL

- ☐ Poor appetite
- ☐ Heavy appetite
- ☐ Changes in appetite
- ☐ Weight Loss/gain
- ☐ Cravings
- ☐ Strong thirst
- ☐ Fevers/Chills
- ☐ Sweat easily
- ☐ Localized weakness
- ☐ Bleed / bruise easily
- ☐ Sudden energy drop (time?)
- ☐ Fatigue
- ☐ Tremors
- ☐ Poor Sleeping
- ☐ Heavy Sleeping
- ☐ Dream disturbed sleep
- ☐ Night sweats
- ☐ Dizziness

SKIN AND HAIR

- ☐ Rashes / hives
- ☐ Itching
- ☐ Dry Skin
- ☐ Dandruff
- ☐ Ulcerations
- ☐ Exzema/Psoriasis
- ☐ Loss of hair
- ☐ Pimples/Acne
- ☐ Fungal infections
- ☐ Recent moles
- ☐Changes in hair or skin texture

Other hair or skin concerns:

HEAD, EYES, EARS, NOSE AND THROAT

- ☐ Concussions
- ☐ Glasses/Contacts
- ☐ Eye strain/pain
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Dry eyes
- ☐ Excessive tearing
- ☐ Poor/blurry vision
- ☐ Night blindness
- ☐ Cataracts/Glaucoma
- ☐ Spots in front of eyes
- ☐ Earaches/infections
- ☐ Ringing in ears
- ☐ Poor heating
- ☐ Sinus problems
- ☐ Post Nasal Drip
- ☐ Excessive phlem color
- ☐ Nose bleeds
- ☐ Recurrent sore throats
- ☐ Swollen glands
- ☐ Sores on lips/tongue
- ☐ Dry mouth
- ☐ Excessive saliva
- ☐ Teeth problems
- ☐ Gum problems
- ☐ TMJ disorder
- ☐ Grinding teeth

☐ **Headaches** (location, triggers, severity)?

Other head and neck concerns:

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Palpitations
- ☐ Fainting
- ☐ Cold hands/feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Phlebitis

Other heart or blood vessel concerns:

RESPIRATION

- ☐ Cough
- ☐ Coughing blood
- ☐ Wheezing
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Pain with deep breath
- ☐ Shortness of breath
- ☐ Tight chest
- ☐ Production of phlegm - color _____
  Is it ☐ thick ☐ thin

Other lung related concerns:

GASTROINTESTINAL

☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Gas/Bloating
☐ Hiccups
☐ Belching
☐ Bad breath
☐ Blood in stools
☐ Mucus in stools
☐ Mucus in stools
☐ Acid regurgitation
☐ Abdominal pain
☐ Itchy anus
☐ Burning anus
☐ Hemorroids/fissures
☐ Hemorroids/fissures

History of chronic laxative use?

Other concerns with your general digestion:

GENITOURINARY

☐ Pain on urination
☐ Frequent urination
☐ Blood in urine
☐ Urgency to urinate
☐ Unable to hold urine
☐ Decrease in flow
☐ Bedwetting
☐ Kidney stones
☐ Impotency
☐ Increased libido
☐ Decreased libido
☐ Premature ejaculation
☐ Nocturnal emissions
☐ Sores on genitals
☐ Frequent urinary tract infections
☐ Chronic yeast infections

If you wake to urinate, how often?

Other concerns with genitals or urinary system:

MUSCULOSKELETAL

☐ Neck pain
☐ Upper back pain
☐ Lower back pain
☐ Hand/wrist pain
☐ Muscle pains
☐ Muscle weakness
☐ Cramps/spasms
☐ General joint pain / stiffness
☐ Shoulder pain
☐ Knee pain
☐ Foot / ankle pain
☐ Hip pain
☐ Joint with limited range of motion _____

Other muscle, joint or bone concerns:

NEUROLOGICAL

☐ Seizures
☐ Loss of balance
☐ Areas of numbness
☐ Ticks
☐ Lack of coordination
☐ Memory loss
☐ Concussion
☐ Depression
☐ Anxiety
☐ Irritability
☐ Easily susceptible to stress
☐ History of emotional / Physical abuse

Have you ever been treated for emotional problems? ☐ Yes ☐ No

Have you ever considered or attempted suicide? ☐ Yes ☐ No

Other neurological or psychological concerns:

GYNECOLOGY

Age of first menses _____ If no longer menstruating, approx date ceased _____

First day of last menses _____ Length between menses: ____ days Duration of period _____ days

☐ Unusual flow ☐ Heavy ☐ Light
☐ Painful periods
☐ Irregular periods
☐ Clots in flow
☐ Vaginal discharge color _____
☐ Vaginal odor
☐ Vaginal dryness
☐ Vaginal sores
☐ Hot Flashes
☐ Breast lumps/soreness

GYNECOLOGY (cont)

Changes in body or psyche prior to menstration (“PMS”)

Date of last PAP: _____ Results were ☐ Nornal ☐ Abnormal ☐ Unsure

If you use birth control, what type and for how long?

Have you ever used hormonal methods for contraception or period regulation?

(i.e. the pill, Depo-Provara, etc.)

Other gynological concerns:

PREGNANCY HISTORY

Number of pregnancies: _____ Births _____ Miscarriages _____ Abortions _____

Were your births relatively normal? Explain:

Other related concerns:

COMMENTS

Please let us know of any concerns you would like to address:

FAMILY HISTORY

	Yes	Who	Comments
Addiction (alcohol/drugs)			
Cancer			
Cardiac disorders (heart disease, high blood pressure, stroke)			
Diabetes			
Digestive /Gastro-intestinal disorders			
Immune disorders (hepatitis, HIV, etc.)			
Mental Illness			
Respiratory disorders (asthma, allergies, etc.)			
Skin disorders (eczema, pso-riasis, etc.)			
Seizure disorders			