Medical Acupuncture

Please fill in the following information as completely as possible. In order for us to verify your insurance benefits, we must have the information listed below. This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

NAME____DATE__________________

ADDRESS____

CITY/STATE/ZIP____

HOME PHONE____________________ EMAIL_____________________________________

BIRTHDATE____________________AGE______MARITAL STATUS ______ Children__________

PLACE OF EMPLOYMENT____

WORK PHONE __________________ BEST # TO REACH YOU__________________________

Have you had an auto accident within the last two years?_____________________________

If yes, please give the date of the accident____

How did you learn about our office?____

Major medical complaint:____

Medications:____

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____

Surgical history:____

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PRIMARY INSURANCE:

MEDICARE _____ WORKCOMP _______ AUTO ______ HEALTH ______

Please supply us with a copy of your insurance card.

Medical Acupuncture

Please mark the appropriate squares in the following list of symptoms.
If you have had a symptom in the PAST and do not have it now, check the box like this: ☑
If you are having the symptom CURRENTLY, fill in the box like this: ■

Liver/Gallbladder

- ☐ Depression / Stress
- ☐ Headaches / Migraines
- ☐ Red / Dry / Itchy Eyes
- ☐ Visual Problems / Blurred Vision
- ☐ Dizziness
- ☐ Gall Stones
- ☐ Feeling of Lump in Throat
- ☐ Clenching Teeth at Night
- ☐ Muscle Cramping / Twitching
- ☐ Neck/Shoulder Pain / Tightness
- ☐ Seizures/Tremors
- ☐ Poor Circulation
- ☐ Soft/Brittle Nails
- ☐ Bitter Taste in Mouth
- ☐ PMS/Menstrual Problems
- ☐ Tendonitis
- ☐ Pain Below Ribcage
- ☐ Do you crave: Sour
- ☐ Tend to be Irritable / Angry

Heart/Small Intestine

- ☐ Heart Palpitations
- ☐ Rapid or Irregular Heartbeat
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Insomnia / Sleep Problems
- ☐ Vivid Dreams / Nightmares
- ☐ Easily Startled
- ☐ Dark Urine
- ☐ Red Complexion
- ☐ Do you crave: Bitter
- ☐ Anxiety / Nervous or Restless

Spleen/Stomach

- ☐ Body Heaviness
- ☐ Hard to get up in Morning
- ☐ Muscles Often Feel Tired
- ___ Energy Level: 1-10 (low to high)
- ☐ Edema (☐ Hands ☐ Feet)
- ☐ Easily Bruising / Bleeding
- ☐ Bad Breath
- ☐ Sweetish Taste in Mouth
- ☐ Lack of Taste
- ☐ Excess or Low Appetite (circle which)
- ☐ Excess or Lack of Thirst (circle which)
- ☐ Nausea / Vomiting
- ☐ Gas / Belching
- ☐ Hemorrhoids
- ☐ Organ Prolapse (i.e. uterus)
- ☐ Chronic Loose Stools
- ☐ Abdominal Pain
- ☐ Indigestion / Heartburn
- ☐ Brain Foggy
- ☐ Mouth Ulcers
- ☐ Tendency to Gain Weight
- ☐ Do you crave: Sweet
- ☐ Over-thinking / Worry

Lung/Large Intestine

- ☐ Bloody Cough
- ☐ Dry Cough
- ☐ Chronic Cough
- ☐ Cough with Sputum
- ☐ Nasal Discharge
  - ☐ White ☐ Yellow ☐ Green
- ☐ Post Nasal Drip
- ☐ Sinus Infection / Congestion
- ☐ Itchy, Red, or Painful Throat
- ☐ Dry Mouth / Nose / Throat
- ☐ Skin Rashes / Hives
- ☐ Snoring
- ☐ Shortness of Breath
- ☐ Allergies / Asthma
- ☐ Low Immunity
- ☐ Catch Colds Easily
- ☐ Bronchitis
- ☐ Black or Bloody Stools
- ☐ Constipation
- ☐ IBS
- ☐ Diarrhea
- ☐ Colitis / Spastic Colon
- ☐ Do you crave: Pungent / Spicy
- ☐ Grief / Sadness

Kidney/Urinary Bladder

- ☐ Urinary Problems (i.e. night-time) ________________
- ☐ Bladder Infection
- ☐ Incontinence
- ☐ Weakness / Pain in Low Back
- ☐ Osteoporosis
- ☐ Feel Cold or Hot Easily (circle which)
- ☐ Cold Hands / Feet
- ☐ Low or Excess Sex Drive (circle which)
- ☐ Dark Circles under Eyes
- ☐ Thyroid Problems ___________________________
- ☐ Poor Memory
- ☐ Hair Loss / Grey Hair
- ☐ Hearing Problems / Tinnitus
- ☐ Cavities
- ☐ Hot Flashes / Night Sweats
- ☐ Impotence or Premature Ejaculation (circle which)
- ☐ Do you crave: Salt
- ☐ Fear