NEW PATIENT INFORMATION

Sebastopol Family Acupuncture

Patient Information
Patient's Name_____Today's Date_____
Street Address_____Apt. # _____
City_____ State _____Zip _____
Home Phone ( ) _____Office ( )
Other Phone ( ) _____Email _____
Birth Date_____ Age _____Gender_____

_single _married __divorced __widowed __domestic partnership _other

Referred by_____

Emergency Contact _____Relationship_____
Emergency Contact Phone # home ( ) _____Office or Cell(____)_____
Physician's Name_____Phone_____
Date of last visit _____

Employment - Please check all that apply
_full-time _part-time _self-employed _student _unemployed _retired

Occupation_____ Number of hours of work/study per week
Employer's Name_____Phone ( )

Billing and Insurance

Note on Insurance
Payment in full is due at the time services are rendered. $80 per visit plus $40 for new patient. Upon request a Superbill will be provided or insurance will be billed. A Superbill is a receipt that you may submit directly to your insurance company to seek reimbursement for payments made. You may call your insurance company to inquire if acupuncture services are covered under your policy.

Primary Insurance_____Phone ( )
Primary Insurance Address
Policy Holder's Name_____Relationship _____Policy # / ID # _____Group# _____

_Insurance billed please
Superbill requests __No, thanks! _ Once a month __At the end of each treatment

Missed Appointment Policy
If you need to change or cancel your appointment please do so with 24 hours notice. Failure to do so will result in being charged $80.

__I understand cancellation policy.

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Confidentiality
Your patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by your authorization, or when required or permitted by law.

Health History

Patient Name_____ Date

Have you had acupuncture treatment before? If so**,** for what reason?

Please indicate any painful / problem areas

1, r, b = left, right, or both sides

past current
__ __ head
__ __ jaw
__ __ neck
__ __ throat
__ __ shoulder 1 r b
__ __ upper arm 1 r b
__ __ elbow 1 r b

past current
__ __ forearm 1 r b
__ __ wrist l r b
__ __ hand l r b
__ __ fingers 1 r b
__ __ chest
__ __ rib / flank
__ __ abdomen

past current
__ __ upper back
__ __ mid-back
__ __ low back
__ __ hip l r b
__ __ thigh l r b
__ __ knee l r b
__ __ calf l r b

past current
__ __ shin l r b
__ __ ankle l r b
__ __ foot l r b
__ __ heel l r b
__ __ toes l r b

other current related symptoms

ST
past current
__ __ nausea / vomiting
__ __ belching
__ __ heartburn
__ __ bad breath
__ __ bleeding gums
__ __ ulcers
__ __ excessive appetite
__ __ change in appetite
__ __ nose bleeds
__ __ difficulty swallowing
__ __ recurring sore throat
__ __ laryngitis/hoarse voice

Sp
past current
__ __ gas
__ __ abdominal bloating
__ __ abdominal pain
__ __ decreased appetite
__ __ indigestion
__ __ low energy/fatigue
__ __ crave sweets
__ __ decreased sense of taste / smell
__ __ sweet taste in mouth
__ __ often feel pensive / thoughtful
__ __ edema

past current
__ __ diarrhea
__ __ constipation
__ __ blood in stools / black
__ __ pus in stools
__ __ hemorrhoids
__ __ anal fissures
__ __ rectal pain

other current related symptoms

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Lu

past current
_ _ frequent colds
_ _ sinus infection
_ _ cough
_ _ cough with blood
_ _production of phlegm
_ _ hay fever or allergies

past current
_ _ asthma
_ _ bronchitis
_ _pneumonia
_ _ COPD

past current
_ _ often feel sad
_ _ crave pungent foods
_ _ dry skin
_ _ itching
_ _ acne
_ _rashes, hives, eczema or psoriasis

other current related symptoms

K

past current
_ _ frequent urination
_ _ urgency to urinate
_ _ pain on urination
_ _ urine/bowel incontinence
_ _ weak urine stream
_ _ blood in urine
_ _ kidney stones
_ _ low back pain
_ _ sore / weak knees
_ _ crave salty foods
_ _ often feel afraid

past current
_ _ frequent urinary tract infections
_ _ frequent vaginal infections
_ _ pelvic inflammatory disease
_ _ abnormal PAP smear
_ _ irregular periods
_ _ premenstrual syndrome
_ _ painful menstrual periods
_ _ abnormal bleeding
_ _ menopause symptoms
_ _ breast lumps

past current
_ _ impotence
_ _ premature ejaculation
_ _ testicular lumps
_ _ prostatitis
_ _ genital itching/ pain
_ _ genital lesions/ discharge
_ _ decreased libido
_ _ ear ringing – low pitch
_ _ ear ringing – high pitch
_ _ decreased hearing
_ _ ear infections

Total Pregnancies_____Living_____Ectopic_____Miscarriages_____
Induced Abortions_____

Other current related symptoms

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Lv.

past current
__ __ dry eyes
__ __ red eyes
__ __ eye inflammation
__ __ blurred vision
__ __ poor night vision
__ __ floaters (spots in the visual field)

__ __ visual changes
__ __ glasses / contact lenses
__ __ cataracts
__ __ crave sour foods

past current
__ __ insomnia
__ __ excessive / vivid dreams
__ __ grinding teeth
__ __ depression
__ __ anxiety / stress
__ __ irritability
__ __ treated for emotional / psychological problems
__ __ indecisiveness
__ __ often feel angry

past current
__ __ migraine
__ __ dizziness
__ __ fainting
__ __ seizures
__ __ localized weakness
__ __ numbness or tingling of limbs
__ __ tremors
__ __ poor concentration
__ __ paralysis
__ __ aversion to wind
__ __ tendinitis
__ __ gallstones

other current related symptoms

Ht

past current
__ __ high blood pressure
__ __ low blood pressure
__ __ palpitations
__ __ irregular heart beat

past current
__ __ chest pain or pressure
__ __ jaw, neck, shoulder or arm pain
__ __ nausea
__ __ swollen hands or feet

past current
__ __ blood clotting disorders
__ __ phlebitis
__ __ poor memory
__ __ crave bitter food

other current related symptoms

YM

past current
__ __ fevers
__ __ frequent or strong thirst
__ __ tend to feel warmer than others
__ __ night sweats
__ __ sweat easily
__ __ prefer cold food and drinks

past current
__ __ chills
__ __ cold hands / feet
__ __ tend to feel colder than others
__ __ cold sweats
__ __ prefer warm food and drink

past current
__ __ headache
__ __ neck stiffness
__ __ concussion
__ __ enlarged lymph

tumors or lumps

past current
__ __ HIV
__ __ TB
__ __ chickenpox
__ __ meningitis
__ __ hepatitis

past current
__ __ gonorrhea
__ __ chlamydia
__ __ syphilis
__ __ genital warts
__ __ herpes oral / genital

past current
__ __ SARS
__ __ west nile

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other past or current infectious diseases

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recent tests and indicate results
cholesterol_____ blood pressure_____mammography
prostate_____ blood work_____STD Check
other tests and results

FAMILY HISTORY Complete for each family member, placing an X in the appropriate box

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood Disorder / Anemia							
Diabetes							
Cancer or Tumors							
Seizures							
High Blood Pressure							
Kidney or Bladder Disorder							
Stomach or Intestinal Disorder							
Drug / Alcohol Use or Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression / Mental Illness							
Suicide Attempt							
Age at Death							

Major Hospitalizations – Please list any hospitalization or surgeries you have undergone

Year Operation or Illness Name of Hospital City and State

Medicines, Herbs, Supplements - Please check any that you are currently taking

__ aspirin
__ ibuprofen
__ acetaminophen (Tylenol)
__ oral contraceptives
__ antacids
__ fiber / laxatives
__ diet pills
__ allergy medication
__ blood thinners
__ blood pressure pills
__ insulin
__ antidepressants
__ sleeping pills
__ tranquilizers
other, please list

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Western Drugs Herbs Vitamins and Supplements

_____

_____

_____

Medication Allergies_____

Food Allergies_____

Habits – Please check any habits which apply to you now or in the past

Coffee __ yes __ no # per day_____ age started _____ age quit _____

Tobacco __ yes __ no # per day_____ age started _____ age quit _____

Marijuana __ yes __ no # per day_____ age started _____ age quit _____

Alcohol __ yes __ no # per day_____ age started _____ age quit _____

Crack / Cocaine __ yes __ no # per day_____ age started _____ age quit _____

Heroin __ yes __ no # per day_____ age started _____ age quit _____

Please describe any restricted diet you follow(ed) now or in the past_____

_____

Please describe your typical daily diet

Breakfast_____ Morning Snack_____

Lunch_____ Afternoon Snack_____

Dinner_____ Evening Snack_____