

Confidential Patient Information Sheet

Patient Information

Name _____ Date _____
Address _____ City _____ State _____
Zip _____ Home phone _____ Work phone _____ Cell _____
Email _____ Have you had acupuncture before? Yes No
Height _____ Weight _____ Age _____ Sex: Male Female Date of birth _____
Occupation _____ Employer _____
In emergency notify (name): _____ Emergency phone number: _____
Marital Status: Single Married Domestic Partner Divorced Widowed Separated
Primary Care Doctor _____ Last seen: _____
How did you hear about Red Phoenix Acupuncture: Yellow Pages Article A Talk Sign/ Drive By
 Brochure Business Card Web site Referred by: _____

Medical Insurance

Insurance Company: _____ *Insured's Name: _____
*Insured's Date of Birth: _____ ID#: _____
Group #: _____ *Insured's Employer: _____
Patient's Relationship to Insured: SELF SPOUSE CHILD OTHER
*If the primary member on the insurance plan is other than the patient, please include their information.

Medical History

Reason for your visit here today: _____

Are you being treated for this condition by anyone else: Yes No
If Yes, who? _____ Phone number: _____
Have these treatments helped? Yes Somewhat Not much Not at all
How does this condition affect you? _____
How long have you had this condition? _____
Known or suspected allergies: _____

Accidents / Hospitalizations / Surgeries in the past 10 years:

Reason	Date / Year(s)
_____	_____
_____	_____
_____	_____

Your general health as a child: Excellent Good Average Poor

Health Inventory

<p><u>Cardiovascular :</u></p> <input type="checkbox"/> Heart Disease <input type="checkbox"/> A Pacemaker <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Stroke <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Edema	<p><u>Emotional / Mental:</u></p> <input type="checkbox"/> Clinical Depression <input type="checkbox"/> ADD or ADHD <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Mood Swings <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Nervousness <input type="checkbox"/> Anxiety <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Dementia	<p><u>Energy & Immunity:</u></p> <input type="checkbox"/> Chronic Fatigue Synd. <input type="checkbox"/> General Fatigue <input type="checkbox"/> Slow Wound Healing <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Chronic Infections <input type="checkbox"/> Frequent Allergies	<p><u>Respiratory:</u></p> <input type="checkbox"/> Pneumonia <input type="checkbox"/> Asthma <input type="checkbox"/> Frequent Colds <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Emphysema <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Pleurisy <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Shortness of Breath
<p><u>Musculo-Skeletal:</u></p> <input type="checkbox"/> Neck / Shoulder Pain <input type="checkbox"/> Muscle Spasms / Cramps <input type="checkbox"/> Arm Pain <input type="checkbox"/> Upper Back Pain <input type="checkbox"/> Mid Back Pain <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Leg Pain <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Joint Pain	<p><u>Head, Eye, Ear, Nose & Throat:</u></p> <input type="checkbox"/> Impaired Vision <input type="checkbox"/> Eye Pain/Strain <input type="checkbox"/> Glaucoma <input type="checkbox"/> Tearing / Dryness <input type="checkbox"/> Impaired Hearing <input type="checkbox"/> Ear Ringing <input type="checkbox"/> Earaches <input type="checkbox"/> Ear Infections <input type="checkbox"/> Headaches <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Teeth Grinding <input type="checkbox"/> Frequent Sore Throats <input type="checkbox"/> TMJ / Jaw Problems <input type="checkbox"/> Hay Fever	<p><u>Genito-Urinary Tract:</u></p> <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Painful Urination <input type="checkbox"/> Dribbling Urination <input type="checkbox"/> Frequent UTI <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Discharge <input type="checkbox"/> Incontinence <p><u>Neurological:</u></p> <input type="checkbox"/> Vertigo / Dizziness <input type="checkbox"/> Paralysis <input type="checkbox"/> Numbness / Tingling <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Seizures / Epilepsy <input type="checkbox"/> Tremors	<p><u>Gastrointestinal:</u></p> <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Changes in Appetite <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Passing Gas <input type="checkbox"/> Heart Burn <input type="checkbox"/> Belching <input type="checkbox"/> Gall Bladder Disease <input type="checkbox"/> Gall Bladder Stones <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea
<p><u>Endocrine:</u></p> <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Diabetes Type I <input type="checkbox"/> Diabetes Type II <input type="checkbox"/> Night Sweats <input type="checkbox"/> Unusual Sweating <input type="checkbox"/> Feeling Hot or Cold	<p><u>Other:</u></p> <input type="checkbox"/> Cancer Type: _____ <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Lupus <input type="checkbox"/> Candida <input type="checkbox"/> Anemia <input type="checkbox"/> Rashes <input type="checkbox"/> Eczema / Hives <input type="checkbox"/> Cold Hand / Feet <input type="checkbox"/> Hemophilia <input type="checkbox"/> Thin / Graying hair	<p><u>Infections:</u></p> <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> HIV/ AIDS <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Strep Throat <input type="checkbox"/> Flu/ Cold <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Whooping Cough	<p><u>Men Only:</u></p> <input type="checkbox"/> Impotence <input type="checkbox"/> Vasectomy Date: _____ <input type="checkbox"/> Prostate problems <input type="checkbox"/> Testicular Pain / Redness / Swelling <input type="checkbox"/> Low libido <input type="checkbox"/> Excessive libido <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Seminal emissions

Women Only:

Are you pregnant right now? Yes No Trying Maybe Birth Control: _____

Age at first period: _____ Date of last menses: _____ Age at menopause: _____

Length of cycle (days): _____ Number of: Pregnancies: _____ Births: _____ Abortions: _____

Miscarriages: _____ Hysterectomy: Yes No Date: _____ Reason: _____

Check all that apply: Low libido Excessive libido Painful Intercourse Clotting

Painful Periods Heavy Flow Scanty Flow Bleeding Between Cycles Irregular Cycles

Vaginal Discharge Breast Lumps / Tenderness Nipple Discharge Infertility

Menopausal Symptoms Premenstrual Problems

Medications

Please list all prescription and over the counter medications you are currently taking:

Drug Name	Reason for taking	For how long	Dose	Frequency

Please list all supplements and herbs you are currently taking: Use another page if necessary.

Supplement	Reason for taking	Potency	Frequency

Lifestyle

(Daily amount used within the past 2 months)

Tobacco: Yes No Amount: _____ Alcohol: Yes No Amount: _____

Caffeine: Yes No Amount: _____ Recreational Drugs: Yes No Amount: _____

Do you feel you are at or near your ideal weight? Yes No Do you have enough energy? Yes No

Typical day's meals:

Breakfast: _____ Lunch: _____

Dinner: _____ Snacks / Other:: _____

Exercise/ Hobbies: _____ Hours of work per week? _____

Highest level of education completed? High School Bachelors Masters Doctorate Other

How would you rate your current stress level? Extreme Very High High Moderate Low

Emotions / Relationships

What would you characterize as your predominate emotion right now? Anxiety / Worry Anger Grief
 Fear / Dread Depression Sadness Happiness Contentment Numbness / Apathy Other

Do you enjoy your work? Yes Usually Sometimes Rarely No

The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Red Phoenix Acupuncture 24 hours prior to any cancellations or changes to my appointment times and that if I do not, I may be charged for the appointment. I hereby authorize payments to Red Phoenix Acupuncture for services rendered. If my insurance company has not paid within 90 days or denies payment, I understand that I am financially responsible for paying the account balance in full.

X Signed: _____ Date: _____

Parent / Guardian (if applicable) _____