Back to Health
with Acupuncture & Nutrition

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy insurance details so we can verify coverage or check benefits. All information you supply is confidential. We comply with all federal privacy standards.

Today's Date (MM/D/YYYY)

Have you consulted an acupuncturist before?

◯ No ◯ Yes **When?** _____

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Your Last Name

Your Social Security Number (for ??? only)

Birth Date (MM/DD/YYYY)

Age

Your First Name

Your Middle Name (or initial)

Gender

◯ Male ◯ Female

Address

Marital Status ◯ Married

◯ Single ◯ Divorced

◯ Widowed ◯ Separated

City

State/Province

ZIP/Postal Code

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Work Phone

May we contact you at work?

◯ Yes ◯ No

Preferred method of contact?

◯ Home Phone ◯ Cell Phone

◯ Work Phone ◯ Email

Primary Care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

◯ Self ◯ Spouse ◯ Parent

Insured's First Name

Insured's Middle Name (or Initial)

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. And are the result of (darken circle):

◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _____

3. Onset (When did you first notice your current symptoms?)

_____

4. Intensity (How extreme are your current symptoms?)

0 ○-○-○-○-○-○-○-○-○-○ **10**
Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)

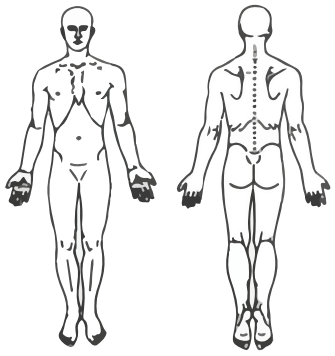
Constant ◯ Comes and goes. How Often? _____

_____

6. Quality of Symptoms
(What does it feel like?)

◯ Numbness
◯ Tingling
◯ Stiffness
◯ Dull
◯ Aching
◯ Cramps
◯ Nagging
◯ Sharp
◯ Burning
◯ Shooting
◯ Throbbing
◯ Stabbing
◯ Other _____

7. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"O" for current condition
"X" for conditions experience in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shot or travel.)

_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem _____

What tends to lessen the problem? _____

10. Prior Interventions (What have you done to relieve the symptoms?)

◯ Prescription medication ◯ Surgery ◯ Ice
◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
◯ Homeopathic remedies ◯ Chiropractic Other _____
◯ Physical therapy ◯ Massage _____

11. What else should Joëlle know about your current condition? _____

_____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. Review of Systems

Acupuncture care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have**.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		None ◯
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back problems	◯	◯	Hip disorders	
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder problems	◯	◯	Elbow/wrist pain	◯	◯	TMJ issues	◯	◯	Poor posture	

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		None ◯
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness	

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		None ◯
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive bruising	

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		None ◯
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia	

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		None ◯
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitive	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea	

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		None ◯
◯	◯	Blurred Vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste	

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		None ◯
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash	

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h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		None
◯	◯	Thyroid Issues	◯	◯	Immune disorders	◯	◯	Hypoglycemia	◯	◯	Frequent infection	◯	◯	Swollen glands	◯	◯	Low energy	◯

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		None
◯	◯	Kidney stones	◯	◯	Infertility	◯	◯	Bed wetting	◯	◯	Prostate issues	◯	◯	Erectile dysfunction	◯	◯	PMS symptoms	◯

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		None
◯	◯	Fainting	◯	◯	Low libido	◯	◯	Poor appetite	◯	◯	Fatigue	◯	◯	Sudden weight gain/loss	◯	◯	Weakness	◯

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
◯	◯	AIDS	◯	◯	Tuberculosis
◯	◯	Alcoholism	◯	◯	Typhoid fever
◯	◯	Allergies	◯	◯	Ulcer
◯	◯	Arteriosclerosis	◯	◯	Other: _____
◯	◯	Cancer			
◯	◯	Chicken pox			
◯	◯	Diabetes			
◯	◯	Epilepsy			
◯	◯	Glaucoma			
◯	◯	Goiter			
◯	◯	Gout			
◯	◯	Heart disease			
◯	◯	Hepatitis			
◯	◯	HIV Positive			
◯	◯	Malaria			
◯	◯	Measles			
◯	◯	Multiple Sclerosis			
◯	◯	Mumps			
◯	◯	Polio			
◯	◯	Rheumatic fever			
◯	◯	Scarlet fever			
◯	◯	STD			
◯	◯	Stroke			

17. Allergies

Are you allergic to any medications?

Yes ◯ No ◯ If Yes, please list:

_____

_____

_____

_____

_____

_____

18. Injuries

Have you ever...

- ◯ Had a fractured or broken bone
- ◯ Had a spine or nerve disorder
- ◯ Been knocked unconscious
- ◯ Been injured in an accident
- ◯ Used a crutch or other support
- ◯ Used neck or back bracing
- ◯ Received a tattoo
- ◯ Had a body piercing

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ◯ Appendix removal
- ◯ Bypass surgery
- ◯ Cancer
- ◯ Cosmetic surgery
- ◯ Elective surgery: _____

_____

- ◯ Eye surgery
- ◯ Hysterectomy
- ◯ Pacemaker
- ◯ Spine: _____

_____

_____

- ◯ Tonsillectomy
- ◯ Vasectomy
- ◯ Other: _____

_____

_____

_____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
◯	◯	Acupuncture
◯	◯	Antibiotics
◯	◯	Birth control pills
◯	◯	Blood transfusions
◯	◯	Chemotherapy
◯	◯	Chiropractic care
◯	◯	Dialysis
◯	◯	Herbs
◯	◯	Homeopathy
◯	◯	Hormone replacement
◯	◯	Inhaler
◯	◯	Massage therapy
◯	◯	Physical therapy
◯	◯	Medications

(Please list below all prescriptions, over-the-counter, natural supplements, enzymes, vitamins and minerals):

_____

_____

_____

_____

_____

_____

FAMILY

19. Family History

Some health issues are hereditary. Tell Joëlle about the health of your immediate family members.

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	_____	◯	◯	_____	_____	◯	◯
Father	_____	◯	◯	_____	_____	◯	◯
Sister 1	_____	◯	◯	_____	_____	◯	◯
Sister 2	_____	◯	◯	_____	_____	◯	◯
Brother 1	_____	◯	◯	_____	_____	◯	◯
Brother 2	_____	◯	◯	_____	_____	◯	◯
_____	_____	◯	◯	_____	_____	◯	◯

20. Are there any other hereditary health issues that you know about?

_____

_____

21. Social History

Tell Joëlle about your health habits and stress levels.

SOCIAL

Alcohol use	◯ Daily	◯ Weekly	How much?	_____
Coffee use	◯ Daily	◯ Weekly	How much?	_____
Tobacco use	◯ Daily	◯ Weekly	How much?	_____
Exercising	◯ Daily	◯ Weekly	How much?	_____
Pain relievers	◯ Daily	◯ Weekly	How much?	_____
Soft drinks	◯ Daily	◯ Weekly	How much?	_____
Water intake	◯ Daily	◯ Weekly	How much?	_____

Hobbies: _____

Prayer or meditation?	◯ Yes	◯ No
Job pressure/stress?	◯ Yes	◯ No
Financial peace?	◯ Yes	◯ No
Vaccinated?	◯ Yes	◯ No
Mercury fillings?	◯ Yes	◯ No
Recreational drugs?	◯ Yes	◯ No

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22. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

23. What is the major stress in your life? _____

24. How much sleep do you average per night? _____ **Hours**

25. What is the type & approximate age of your mattress & pillow? _____

26. What is your preferred sleeping position? _____

27. Describe your typical eating habits: ◯ Skip breakfast ◯ Two meals a day ◯ Three meals a day ◯ Snacking between meals

28. What would be the most significant thing that you could do to improve your health?

_____

29. In addition to the main reason for your visit today, what additional health goals do you have? _____

_____

Acknowledgments

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ **I instruct Joëlle to deliver the care that, in her professional judgment, can best help me in the restoration of my health. I also understand that the care offered in this practice is based on the best available evidence and designed to reduce or correct <<<<<we need relevant text here>>>>>. Acupuncture is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials _____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials _____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: _____

_____ Signature

_____ Date (MM/DD/YYYY)

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