

New Patient Information

*NOTE: 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
authorization to do so.*

Name: _____ Date: _____
First Middle Last

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone # () _____

Driver's License # _____ Email _____

Date of Birth: _____ Age: _____ Sex: _____ Height: _____ Weight: _____

Occupation: _____ Employer: _____

Employer Address: _____

Marital Status: M S D W Name of Spouse: _____

Number of Children: Boys _____ Ages _____ Girls _____ Ages _____

Emergency Contact Name/Phone # _____

Referred by: _____

Please answer the following questions by circling the correct answer

Do you have a tendency to faint?	Yes No	Are you HIV positive?	Yes No
Do you have a pacemaker?	Yes No	Have you ever had Hepatitis?	Yes No
Do you bleed for a long time?	Yes No	(Women) Are you pregnant?	Yes No

New Patient Health Questionnaire

Chief Complaint – What is your condition? How is it developed? What treatment have you received, both conventional and alternative?

Duration of present condition? _____

List all hospitalizations (including accidents, surgeries, fractures, psychiatric, etc.)

Approximate Date	Purpose of Hospitalization	Treatment Received

Medications that you are allergic to, if there are any

Medications you are presently taking:

Name	Dosage	Name	Dosage
1.		4.	
2.		5.	
3.		6.	

Supplements or over-the-counter drugs you are taking:

Name	Dosage	Name	Dosage
1.		3.	
2.		4.	

Are you aware of any food sensitivity? _____

Do you have cravings to any special foods? _____

List any major medical problems that any of your blood relatives have had _____

Please check any symptoms you currently have or have had in the past year.

General

- Aversion to heat
- Aversion to cold
- Chills
- Fevers
- Sweat spontaneously
- Night sweating
- Lack of sweating
- Headache
- Low energy/Fatigue
- Excess thirst
- Poor appetite
- Excess appetite
- Excessive hair loss
- Weight loss
- Weight gain

Emotional

- Insomnia/Troubling dreams
- Irritability
- Forgetful
- Mind not clear
- Cry uncontrollably
- Depressed
- Anxiety
- Unrestrained joy
- Difficulty expressing emotions

Diet/Lifestyle

- Vegetarian
- Eat much fried foods
- Eat much meats
- Smoke cigarettes
- Drink alcohol
- Drink coffee
- Use drugs
- Eat a lot of sweets
- Exercise regularly
- Exercise excessively

Head & Neck

- Sore throats
- Sinus problems
- Bleed nose
- Hearing loss
- Visual disturbances

Respiratory

- Shortness of breath
- Cough
- Cough up blood
- Asthma or wheezing
- Pneumonia
- Hay fever
- Bronchitis

Cardiovascular

- Chest pain
- High blood pressure
- Low blood pressure
- Irregular heart beat
- Poor circulation
- Swelling of ankles
- Varicose veins

Gastrointestinal

- Abdominal pain
- Bloating
- Belching/Gas
- Constipation
- Diarrhea/loose stools
- Bloody stools
- Black stools
- Heartburn/reflux
- Hemorrhoids
- Indigestion
- Stomachache
- Nausea
- Vomiting

Genitourinary

- Dark urine
- Blood in urine
- Cloudy urine
- Burning urination
- Scanty urine
- Profuse urine
- Frequent urination
- Poor bladder control

Others

-
-

Musculoskeletal

- Back pain
- Arthritis
- Muscle pain
- Cramps
- Painful joints
- All over weakness

Skin

- Dark circles around eye
- Dry skin
- Acne
- Brittle nails
- Rash
- Eczema
- Itching

Neurological

- Fainting
- Convulsions
- Paralysis
- Stroke
- Seizures

Men Only

- Prostate problems
- Pain in testicles
- Impotence
- Low sex drive

Women Only

- Pre-menstrual pain
- Menstrual pain
- Irregular period
- Swelling in breast
- Pain in breast

Misc

- ADD/Autism
- Allergies
- Auto Immune disease
- Cancer
- Diabetic
- Thyroid disease

INSURANCE PAYMENTS

Insurance charge amount according to contracting price

SELF PAYMENT SCHEDULE

Initial Regular Consultation	\$80/Session
Initial Fertility Consultation	\$120/Session
Acupuncture	\$140/Session

*The consultation fee is applied at the first visit only.

Insurance

Currently, we are in network with Aetna, Blue Cross Blue Shield, United Healthcare and Veterans Insurance. We will bill the insurance directly. We will check with your provider to determine your coverage. Insurance coverage includes consultations, acupuncture sessions and related modalities. Herbs and supplements are not included.

Return Policy

Custom herbs cannot be refunded. Refunds will only be issued for *unopened* products returned within 30 days from the purchase. No refunds after 30 days.

I have read and agree to the fee schedule and refund policy of the preceding paragraphs.

Signature

Date