Holistic Choices

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Licensed Acupuncturist

Name:______________________ Home phone:______________________

Address:______________________ Work phone:______________________

City:__________ Zip:__________ Cell phone:______________________

Date of Birth:__________ Age:__________ Email (optional):______________________

Height:__________ Weight:__________ Which number is best for your reminder calls the day before your appointments?__________

Primary Physician:______________________

Insurance:______________________ Occupation:______________________

ID#:__________ Group#:__________ Referred to this office by:______________________

PLEASE ANSWER "Y" or "N":

Have you had acupuncture before? ____
Are you nervous about needles? ____
Are you extremely tired right now? ____
Are you extremely hungry right now? ____

Do you have a pacemaker? ____
Do you have a tendency to faint? ____
Are you undergoing any other treatments now? ____
Women: Are you pregnant? ____

REASON FOR TODAY'S VISIT______________________

____

WHEN DID THIS CONDITION BEGIN?______________________

HOW DID THIS CONDITION DEVELOP? HOW DID IT START?______________________

____

Please underline: HAVE YOU EVER HAD IN THE PAST...? / Please circle: DO YOU CURRENTLY HAVE...?

hepatitis jaundice alcoholism gall bladder disease high blood pressure anemia cancer A.I.D.S. food/drug poisoning heart disease rheumatic fever scarlet fever pneumonia pleurisy/TB allergies/asthma mental disorder epilepsy miscarriage nephritis diabetes bladder disease gonorrhea/syphillis rectal disease drug problem polio/meningitis

Please circle: HAS YOUR MOTHER OR FATHER EVER HAD:

cancer stroke kidney disease TB diabetes mental disorder heart trouble asthma allergies high blood pressure arthritis ulcers drug problem other______________________

Hospitalization/surgeries/radiation treatments:

____

Major accidents, falls, etc.:

____

Allergies to drugs, chemicals, foods, environment:

____

List medicines, herbs, vitamins taken:

____

Do you exercise regularly? If so, what kind?

____

Do you have difficulty sleeping?

____

How many hours do you sleep per night?

____

PLEASE MARK AREAS OF PAIN/DISCOMFORT