Patient Confidential Contact Information

Date_____

First_____MI____Last_____Preferred Name_____

Address_____
City _____ State _____ Zip _____

DOB:____/____/____Gender: M ____ F____ Marital Status: Single _____ Married _____ Widowed _____

Phone Number - _____

E-mail (only used if necessary, never given out) _____

Would you like to receive an email Chinese medicine newsletter? Yes ____ No ____

Who is your Primary Care Physician?
_____

What kind of doctor are they? MD ____ DO ____ DC ____ ND ____ other ____
please specify _____

In case of emergency, who should we contact?

Name _____ Phone _____

How did you hear about our practice?_____

Patient Medical History

Patient Name _____

Date of first visit ____/____/____ **Male** ____ **Female** ____ **Age** _____ **DOB** ____/____/____

What is the reason for your visit today?

_____

Please state and describe the problem(s) or condition(s) concerning you:

#1 Problem (most troublesome): _____

_____

When did it occur? _____

How? _____

What have you tried to help it out?_____

Describe related symptoms:_____

_____

Please list any other current complaints or illnesses:

_____

_____

_____

_____

Please list your current medications, and what they are for:

_____

_____

_____

_____

Please list all past serious illnesses, hospitalizations, or surgeries, including childhood diseases:

_____

_____

_____

_____

Please list any known allergies (food, environmental, chemicals or drugs):

_____

_____

Please list any implants, metal plates, artificial joints, pacemakers, insulin pumps, stents, biomechanical devices, etc.:

_____

_____

_____

Check all that presently apply to you:

____ very hungry	____ pregnant or maybe	____ very upset
____ very full	____ recently gave birth	____ very anxious/nervous
____ missed a meal	____ menstruating	____ very sad
____ exhausted	____ had alcohol today	____ very angry
____ bleeding disorder	____ down on myself	
____ bruise easily	____ hepatitis ___ A ___ B ___ C	____ HIV/AIDS
____ faint easily	____ high blood pressure	____ heart problems
____ sugar unstable	____ epilepsy	____ breathing problems
____ sores, boils	____ skin rash	____ staph infection
____ contagious disease	____ fever	____ infection _____

Patient Name _____

I understand that the acupuncturist needs good information to help facilitate my healing. I acknowledge that the above information is true, correct, and complete to the best of my knowledge and belief.

_____

Signature of Patient or Legal Guardian **Date**

_____

Susan McKibben, L. Ac, LMBT **Date**