ACUPUNCTURE CONTINUUM

CONFIDENTIAL CASE HISTORY

This is a CONFIDENTIAL health profile to help us determine the best treatment plan for you. If you have any questions, please ask.

Date ____________________________

Patient Information

Name ____ Soc. Sec. #___________________________________
LAST NAME FIRST NAME MIDDLE INITIAL

Address ____

City ____ State____________________ Zip__________________________

Home Phone __________________________Work Phone __________________________E-mail address_________________

Sex: M 1 F 1 Age______________ Birthdate___________________________ Single 1 Married 1 Widowed 1 Divorced 1

Weight ____ Height____

Employer ____Occupation ____

Business Address____

Whom may we thank for referring you? ____

Primary Insurance

Person Responsible for Account____
LAST NAME FIRST NAME MIDDLE INITIAL

Relationship to Patient_____________________________ Birthdate_________________ Soc. Sec. # ______________________

Address____ Home Phone ______________________

Person Responsible Employed by____ Occupation___________________________

Business Address____

Insurance Company____

Address____

Phone____Adjustor______________________________________

Policy # _________________________________ Group # ______________________________ Effective Date________________

Insurance Type: HMO 1 PPO 1 ASHN 1 Worker's Comp 1 Auto 1 Other____

Deductible $__________________ Amount Met $_________________Limitation on Visits___________ Copay $____________

Assignment and Release

I, the undersigned certify that I (or my dependent) has insurance coverage with____
NAME OF INSURANCE COMPANY(IES)

and assign directly to ____ all insurance benefits, if any, otherwise payable to me for
NAME OF ACUPUNCTURIST

services rendered . I hereby authorize release of all information necessary to secure payment of benefits. I further authorize the use of my signature on all insurance submissions. If my health insurance company denies payment to the acupuncturist I understand that I am responsible to her for the full amount.

Signature:____Date:____________________________

Health Profile

Date of last medical exam: ______________ Who is your Doctor? _______________ Phone # ________________

Have you received acupuncture before? Yes No When? __________________With Whom?_________________________

Please indicate any significant illnesses you or a blood relative (grandparent, parent or sibling) have had:

Illness	You	Your Relative	Approx. Date	Illness	You	Your Relative	Approx. Date
Cancer			________	Diabetes			________
Hepatitis			________	Heart Disease			________
High Blood Pressure			________	Seizures/Epilepsy			________
Hemophilia			________	Emotional Disorders			________
Infectious Diseases			________	Tuberculosis			________

Sexually Transmiitted Disease: Gonorrhea Syphilis AIDS HPV Chlamydia Herpes Date:________

Do you have any prosthetic devices, pacemakers, metal pins, etc. in your body? Yes No

Explain:______________________

List any medications and supplements you are currently taking: (Continue on back if necessary.)

Medicine	Dosage	Reason	How Long	Prescribed by:
______________________	____________	______________________________	____________________	__________________
______________________	____________	______________________________	____________________	__________________
______________________	____________	______________________________	____________________	__________________

Please indicate the use and frequency of the following:

	Yes	No	How Much?		Yes	No	How Much?		Yes	No	How Much?
Coffee/Black Tea	____	____	______	Tobacco	____	____	______	Water Intake	____	____	______
Recreational Drugs	____	____	______	Alcohol	____	____	______	Soda Pop	____	____	______
Exercise	____	____	______	Relaxation	____	____	______				

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Your Comments:
Spouse or Significant Other					________________________________
Friends					________________________________
Career					________________________________
Quality of Life					________________________________
Sex					________________________________

What is the main problem/s for which you are seeking treatment?

(1)

(2)

Please rate the severity of your condition (on a scale of 1 to 10, 10 is the worst and 1 is the best):

How long have you had this health concern?

Is there any time of day or night in which your condition is worse?

What makes your condition better? (rest, heat, ice, etc.)

What makes your health concern worse? (exercising, certain movements, heat, cold etc.)

What other forms of treatment have you sought for this condition, when did you have these treatments, and were they helpful?

List in their order of priority any other health problems you have now:

(3)

(4)

(5)

(6)

List any allergies, food sensitivities or food cravings that you have.

List any accidents, surgeries, or hospitalizations (include date).

CLINICAL NOTES

(PHYSICIAN'S USE)

Onset Location Duration Characteristics Aggravate/Alleviate Related Factors Treatment Significance

Please check off any of the following symptoms you have ever had. Use the following codes:

+ I have this symptom often

- I have this symptom sometimes

If you never have the symptom, please leave it blank.

____ Palpitations
____ Shortness of breath when resting
____ Shortness of breath on exertion
____ Spontaneous sweating
____ Fatigue
____ Listlessness
____ Discomfort in or stuffy chest
____ Cold limbs
____ Body usually cold
____ Cold hands and feet
____ Weak/Shallow breathing
____ Heavy sweating
____ Coma
____ Blue lips
____ Dizziness
____ Insomnia
____ Dream disturbed sleep
____ Poor long term memory
____ Anxiety
____ Propensity to be startled
____ Pale lips
____ Mental restlessness
____ Uneasiness/ fidgetiness
____ Low fever or feeling of heat in the evening
____ Sweating at night
____ Thirst
____ Mouth sores
____ Tongue sores
____ Feeling agitated
____ Impulsiveness
____ Dark yellow urine
____ Bitter taste in mouth
____ Sweet taste in mouth
____ Mental confusion
____ Depression
____ Rattling sound in the throat
____ Inability to speak
____ Pain radiating down left arm or shoulder
____ Pain under the sides of rib cage
____ Frequent sighing
____ Frequent hiccups
____ Moodiness
____ Nausea
____ Vomiting
____ Stomach Pains
____ Poor appetite
____ Acid regurgitation
____ Belching
____ Noisy Stomach
____ Feeling of a lump in the throat
____ Difficulty swallowing
____ Vomiting blood
____ nosebleeds
____ abdominal pain
____ Masses in the abdomen
____ Irritability
____ Angry outbursts
____ Ear ringing
____ Neck and shoulder pain
____ Constipation
____ Loose stool
____ Diarrhea
____ Blood in the stool
____ Alternation of constipation & diarrhea
____ Hemorrhoids
____ Coughing up blood
____ Fever
____ Convulsions
____ Neck stiffness
____ Bell's palsy
____ Sudden unconsciousness
____ Paralysis
____ Numbness or tingling of limbs
____ Jaundice
____ Blurred vision
____ "Floaters" in the eye
____ Muscle weakness
____ Muscle spasms
____ Muscle cramps
____ Brittle nails
____ Dry mouth
____ Dry throat
____ Frequent shouting in anger
____ Flatulence
____ Cough
____ Watery sputum
____ weak voice
____ Dislike to speak
____ Dislike of cold
____ Daytime sweating
____ Propensity to catching colds
____ Feeling of heat in the afternoon
____ Hoarse voice
____ Tickly throat
____ Dry skin
____ Stuffy nose
____ Runny nose
____ Sneezing
____ Aversion to cold
____ Body aches (that flu feeling)
____ Sore throat
____ Swelling of face and eyes
____ Dislike of lying down
____ Asthma
____ Chilliness
____ Edema
____ Feeling of heaviness of the head
____ Feeling of fullness after eating
____ Weak arms and legs
____ Cannot taste
____ Feeling of heaviness in body
____ Burning sensation of the anus
____ Difficulty concentrating
____ Vertigo
____ Poor short term memory
____ Aching in the bones
____ Dry mouth at night
____ Low back pain
____ Knee pain
____ Weak legs
____ Frequent urination
____ Difficult urination
____ Painful urination
____ Incontinence
____ Headache at the temples
____ Headache behind the eye
____ Headache at the back of head
____ Frequent urination @ night
____ Difficulty inhaling
____ Difficulty exhaling
____ Edema in the legs
____ Low sex drive
____ Excessive sexual desire
____ Phlegm in throat
____ Desire to lie down
____ Burning sensation in stomach
____ Constant Hunger
____ Swelling and pain in gums
____ Bleeding gums
____ Bad breath
____ Difficulty digesting fats
____ Lack of courage
____ Lack of initative
____ Timidity

WOMEN:
____ PMS
____ Breast distension
____ Vaginal discharge
____ Vaginal itching
____ Lack of period
____ Infertility

MEN:
____ Pain or swelling of scrotum
____ Impotence
____ Premature ejaculation

EMERGENCY CONTACTS:

In case of an emergency, please contact:

1. Name:______________________________ Phone #s:______________________________

   Address:____

2. Name:______________________________ Phone #s:______________________________

   Address:____

3. Name:______________________________ Phone #s:______________________________

   Address:____