

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 PPO ASHN Worker's Comp Auto 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 Transmitted 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

EMERGENCY CONTACTS:

In case of an emergency, please contact:

1. Name: _____ Phone #s: _____

Address: _____

2. Name: _____ Phone #s: _____

Address: _____

3. Name: _____ Phone #s: _____

Address: _____