PERSONAL INFORMATION

PATIENT NAME: LAST	FIRST	MIDDLE
ADDRESS:		
TEL.: HOME ( ) -	MOBILE ( ) -	WORK ( ) -
FAX: ( ) -	EMAIL:	
DATE OF BIRTH:	AGE:	SOCIAL SECURITY NO.:
EMERGENCY CONTACT:	TEL.: ( ) -	RELATIONSHIP:
REFERRED BY:		
STATUS: [ ] MARRIED [ ] SINGLE [ ] DIVORCED [ ] WIDOWED [ ] OTHER ________________________________		

EMPLOYMENT INFORMATION

EMPLOYMENT STATUS: [ ] FULL TIME [ ] PART-TIME [ ] RETIRED [ ] UNEMPLOYED [ ] STUDENT	
EMPLOYER NAME:	EMPLOYER TEL: ( ) -
EMPLOYER ADDRESS:	

PRIMARY HEALTHCARE PROVIDER

PRIMARY PHYSICIAN:	TEL.: ( ) -
PHYSICIAN ADDRESS:	
DATE OF LAST VISIT:	DATE OF INJURY/ONSET OF ILLNESS:

INSURANCE / SUPERBILL INFORMATION

INSURANCE COMPANY:	POLICY HOLDER'S NAME:
POLICY NAME (IF APPLICABLE):	EMPLOYER NAME (IF APPLICABLE):
POLICY NO.:	
INSURANCE COMPANY TEL.: ( ) -	INSURANCE COMPANY FAX.: ( ) -

Illness and Treatment Information

Have you ever had an acupuncture treatment? When and for what reason? [ ] No [ ] Yes
Are you presently being treated for a medical condition? Please describe. [ ] No [ ] Yes
Please briefly describe any chronic pain?
What health issue do you want treated? Please describe as fully as possible.
Have you been using other medical treatments for relief of this issue? Please describe. [ ] No [ ] Yes
Do you have other health concerns? Please Describe. [ ] No [ ] Yes

Family History Information: Please complete for each family member, placing an X in the appropriate box:

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood Disorder/Anemia							
Diabetes							
Cancer Or Tumors							
Seizures							
High Blood Pressure							
Kidney Or Bladder Disorder							
Stomach Or Intestinal Disorder							
Drug Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression/Mental Illness							
HIV							
Hepatitis							
Other							
Age Of Death							

Major Hospitalizations: Write in any recent hospitalizations for serious injury or illness below.

Year	Operation or Illness	Name of Hospital	City and State
Year	Operation or Illness	Name of Hospital	City and State
Year	Operation or Illness	Name of Hospital	City and State
Year	Operation or Illness	Name of Hospital	City and State

Previous pregnancies:

Total Pregnancies	Living	Ectopic	Miscarriages	Induced Abortions

Medicines: Mark an X in the box next to any of the following that you are now taking:

[ ] Aspirin	[ ] Ibuprofen	[ ] Acetaminophen(Tylenol)	[ ] Other: ______________________________
[ ] Antacids	[ ] Laxatives	[ ] Cold Tablets	[ ] Vitamins: __________________________
[ ] Oral Contraceptives	[ ] Diet Pills	[ ] Tranquilizers	[ ] Herbs: ____________________________
[ ] Fiber Supplements	[ ] Sleeping Pills	[ ] Hay Fever Tablets	
[ ] Blood Pressure Pills	[ ] Blood Thinning Pills	[ ] Insulin, Diabetic Pills	

Drug Allergies: Please list.

Habits: Please check any of the habits listed below which apply to you now or in the past.

Coffee:	[ ] No [ ] Yes	Cups per day/week	Age Started	Age Quit
Tobacco:	[ ] No [ ] Yes	Cigarettes per day/week	Age Started	Age Quit
Alcohol:	[ ] No [ ] Yes	Use per day/week	Age Started	Age Quit
Marijuana:	[ ] No [ ] Yes	Use per day/week	Age Started	Age Quit
Crack/Cocaine:	[ ] No [ ] Yes	Use per day/week	Age Started	Age Quit
Heroine:	[ ] No [ ] Yes	Use per day/week	Age Started	Age Quit
Other: ______________________________		Use per day/week	Age Started	Age Quit
Other: ______________________________		Use per day/week	Age Started	Age Quit

HEALTH: CHECK ALL THAT APPLY:

GENERAL

PAST	CURRENT	CONDITION
[ ]	[ ]	POOR APPETITE
[ ]	[ ]	EXCESSIVE APPETITE
[ ]	[ ]	INSOMNIA
[ ]	[ ]	FATIGUE
[ ]	[ ]	FEVERS
[ ]	[ ]	NIGHT SWEATS
[ ]	[ ]	SWEAT EASILY
[ ]	[ ]	CHILLS
[ ]	[ ]	LOCALIZED WEAKNESS
[ ]	[ ]	POOR COORDINATION
[ ]	[ ]	CHANGE IN APPETITE
[ ]	[ ]	STRONG THIRST
[ ]	[ ]	OTHER: ____________

SKIN & HAIR

PAST	CURRENT	CONDITION
[ ]	[ ]	RASHES
[ ]	[ ]	HIVES
[ ]	[ ]	ITCHING
[ ]	[ ]	ECZEMA
[ ]	[ ]	PIMPLES
[ ]	[ ]	DRYNESS
[ ]	[ ]	TUMORS, LUMPS

HEAD & NECK

PAST	CURRENT	CONDITION
[ ]	[ ]	DIZZINESS
[ ]	[ ]	FAINTING
[ ]	[ ]	NECK STIFFNESS
[ ]	[ ]	ENLARGED LYMPH GLANDS
[ ]	[ ]	HEADACHES
[ ]	[ ]	CONCUSSIONS
[ ]	[ ]	OTHER: ____________

EARS

PAST	CURRENT	CONDITION
[ ]	[ ]	INFECTION
[ ]	[ ]	RINGING
[ ]	[ ]	DECREASED HEARING
[ ]	[ ]	OTHER: ______________

EYES

PAST	CURRENT	CONDITION
[ ]	[ ]	BLURRED VISION
[ ]	[ ]	VISUAL CHANGES
[ ]	[ ]	POOR NIGHT VISION
[ ]	[ ]	SPOTS
[ ]	[ ]	CATARACTS
[ ]	[ ]	GLASSES / CONTACTS
[ ]	[ ]	EYE INFLAMMATION
[ ]	[ ]	OTHER: ______________

NOSE, THROAT, MOUTH

PAST	CURRENT	CONDITION
[ ]	[ ]	NOSE BLEEDS
[ ]	[ ]	SINUS INFECTIONS
[ ]	[ ]	HAY FEVER OR ALLERGIES
[ ]	[ ]	RECURRING SORE THROATS
[ ]	[ ]	GRINDING TEETH
[ ]	[ ]	DIFFICULTY SWALLOWING

CARDIOVASCULAR

PAST	CURRENT	CONDITION
[ ]	[ ]	HIGH BLOOD PRESSURE
[ ]	[ ]	LOW BLOOD PRESSURE
[ ]	[ ]	BLOOD CLOTS
[ ]	[ ]	PALPITATIONS
[ ]	[ ]	FAINTING
[ ]	[ ]	PHLEBITIS
[ ]	[ ]	CHEST PAIN
[ ]	[ ]	IRREGULAR HEART BEAT
[ ]	[ ]	COLD HANDS / FEET
[ ]	[ ]	SWELLING OF HANDS / FEET
[ ]	[ ]	OTHER: ______________

RESPIRATORY

PAST	CURRENT	CONDITION
[ ]	[ ]	ASTHMA
[ ]	[ ]	BRONCHITIS
[ ]	[ ]	FREQUENT COLDS
[ ]	[ ]	CHRONIC OBSTRUCTIVE PULMONARY DISEASE
[ ]	[ ]	PNEUMONIA
[ ]	[ ]	COUGH
[ ]	[ ]	COUGHING BLOOD
[ ]	[ ]	PRODUCTION OF PHLEGM
[ ]	[ ]	OTHER: ________________

GASTRO-INTESTINAL

PAST	CURRENT	CONDITION
[ ]	[ ]	NAUSEA
[ ]	[ ]	VOMITING
[ ]	[ ]	DIARRHEA
[ ]	[ ]	BELCHING
[ ]	[ ]	BLOOD IN STOOLS/BLACK STOOLS
[ ]	[ ]	BAD BREATH
[ ]	[ ]	RECTAL PAIN
[ ]	[ ]	HEMORRHOIDS
[ ]	[ ]	CONSTIPATION
[ ]	[ ]	PAIN OR CRAMPS
[ ]	[ ]	INDIGESTION
[ ]	[ ]	GALL BLADDER DISORDER
[ ]	[ ]	GAS
[ ]	[ ]	OTHER: _______________

GENITO-URINARY

PAST	CURRENT	CONDITION
[ ]	[ ]	KIDNEY STONES
[ ]	[ ]	PAIN OR URINATION
[ ]	[ ]	FREQUENT URINATION
[ ]	[ ]	BLOOD IN URINE
[ ]	[ ]	URGENCY TO URINATE
[ ]	[ ]	UNABLE TO HOLD URINE
[ ]	[ ]	OTHER: _______________

MALE

PAST	CURRENT	CONDITION
[ ]	[ ]	PAIN / ITCHING GENITALIA
[ ]	[ ]	GENITAL LESIONS / DISCHARGE
[ ]	[ ]	IMPOTENCE
[ ]	[ ]	WEAK URINARY STREAM
[ ]	[ ]	LUMPS IN TESTICLES
[ ]	[ ]	OTHER: ______________

FEMALE

PAST	CURRENT	CONDITION
[ ]	[ ]	FREQUENT URINARY TRACT INFECTIONS
[ ]	[ ]	FREQUENT VAGINAL INFECTIONS
[ ]	[ ]	PAIN / ITCHING OF GENITALIA
[ ]	[ ]	GENITAL LESIONS / DISCHARGE
[ ]	[ ]	PELVIC INFLAMMATORY DISEASE
[ ]	[ ]	ABNORMAL PAP SMEAR
[ ]	[ ]	IRREGULAR MENSTRUAL PERIODS
[ ]	[ ]	PAINFUL MENSTRUAL PERIODS
[ ]	[ ]	PREMENSTRUAL SYNDROME
[ ]	[ ]	ABNORMAL BLEEDING
[ ]	[ ]	MENOPAUSAL SYNDROME
[ ]	[ ]	BREAST LUMPS
[ ]	[ ]	OTHER

NEUROLOGICAL

PAST	CURRENT	CONDITION
[ ]	[ ]	SEIZURES
[ ]	[ ]	TREMORS
[ ]	[ ]	NUMBNESS/TINGLING OF LIMBS
[ ]	[ ]	CONCUSSION
[ ]	[ ]	PAIN
[ ]	[ ]	PARALYSIS
[ ]	[ ]	OTHER: _______________

PSYCHOLOGICAL

PAST	CURRENT	CONDITION
[ ]	[ ]	DEPRESSION
[ ]	[ ]	ANXIETY / STRESS
[ ]	[ ]	IRRITABILITY
[ ]	[ ]	TREATED FOR EMOTIONAL OR PSYCHOLOGICAL PROBLEMS
[ ]	[ ]	OTHER: _______________

INFECTION SCREENING

PAST	CURRENT	CONDITION
[ ]	[ ]	HIV
[ ]	[ ]	TB
[ ]	[ ]	HEPATITIS
[ ]	[ ]	GONORRHEA
[ ]	[ ]	CHLAMYDIA
[ ]	[ ]	SYPHILIS
[ ]	[ ]	GENITAL WARTS
[ ]	[ ]	HERPES: ORAL
[ ]	[ ]	HERPES: GENITAL

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by Hasan Tas Sume, a licensed acupuncturist.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the clinic as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: ______________________________ Date: ____________________

Printed Name: ______________________________ Date of Birth: ______________

Address: ____

City: ____________________ State: __________ Zip Code: __________

Phone: ________________________