A Touch of Health Chiropractic & Acupuncture Clinic

Date_____

PATIENT INFORMATION

Patient Full Name: _____(Legal)
Prefer to be called:_____
Birth Date: ____/____/____ Age: ____ Gender: F / M
Social Security Number:_____
Email Adress_____**(checked frequently)**
Marital Status: □ Married □ Separated □ Widowed □ Single
Name of Spouse _____
Spouse's Date of Birth _____/____/____

CURRENT ADDRESS AND PHONE

Street _____
City _____ State _____ Zip _____
Home Phone (_____) _____Cell Phone (_____) _____

INSURANCE

Insurance Carrier_____
Primary Insured Name_____
Insured Birth Date_____/____/____
Is patient covered by additional insurance? YES NO
If YES, Secondary Insurance _____
Primary Insures Name (Secondary)_____

EMPLOYMENT

Employer_____
Occupation_____
Employer Address _____
Employer City, State, Zip code_____

Who should we contact in the event of an emergency? _____
Phone (_____) _____
Who can we thank for referring you? _____

Acupuncture Informed Consent to Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist(s) who now or in the future treat me.

I understand that methods of treatment may include, but are not limited to, acupuncture, Chinese herbal medicine, and nutritional counseling. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness, or tingling near the needling sites that may last a few days, and dizziness or fainting, Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax) Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment, which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administration staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Printed Name: _____

Patient Signature: _____ Date: _____

(Or Patient Representative)

Present Complaints

Patient:_____

Reason for your visit

_____

_____

When did symptoms begin:_____

Is this condition getting progressively worse? YES NO

Is the pain constant or does it come and go? _____

Circle type of pain

Sharp Dull Throbbing Numb Achy Shooting Burning Tingling Cramps Stiff

How often do you have this pain?_____

What makes it better?_____

What makes it worse?_____

When, during the day, is it worse?_____

Does it interfere with your: ____work

____sleep

____daily routine

____recreation

List other doctors seen for this condition:

_____

_____

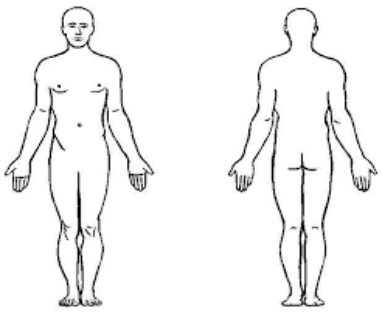
Please mark on the following scale your level of pain.

If more than one symptom, please indicate a level of pain for each:

No discomfort…….Worst possible

0 1 2 3 4 5 6 7 8 9 10

Mark with an X where you have pain, numbness, or tingling:———————->



Health Questionnaire

Please check mark each of the conditions below that YOU are currently

Patient:_____ Date:_____

Musculo Skeletal System

◊ Low back pain
◊ Mid back pain
◊ Pain between shoulders
◊ Neck pain
◊ Arm problems
◊ Leg problems
◊ Swollen joints
◊ Painful joints
◊ Stiff joints
◊ Sore muscles
◊ Weak muscles
◊ Walking problems
◊ Spasms
◊ Broken bones
◊ Shoulder pain

Cardio-Vascular Respiratory

◊ Chest pain
◊ Pain over heart
◊ Difficult breathing
◊ Persistent cough
◊ Coughing phlegm
◊ Coughing blood
◊ Rapid heartbeat
◊ Blood pressure problems
◊ Heart problems
◊ Lung problems
◊ Varicose veins

Genito-Urinary System

◊ Bladder trouble
◊ Excessive urination
◊ Scanty urination
◊ Painful urination
◊ Discolored urine

Female

◊ Vaginal discharge
◊ Vaginal bleeding
◊ Vaginal pain
◊ Breast pain
◊ Lumps on the breast

Nervous System

◊ Numbness
◊ Loss of feeling
◊ Paralysis
◊ Dizziness
◊ Fainting
◊ Headaches
◊ Muscle jerking
◊ Convulsions
◊ Forgetfulness
◊ Confusion
◊ Depression
◊ Insomnia

Gastro-Intestinal System

◊ Poor appetite
◊ Excessive hunger
◊ Difficult chewing
◊ Difficult swallowing
◊ Excessive thirst
◊ Nausea
◊ Vomiting Blood
◊ Abdominal pain
◊ Diarrhea
◊ Constipation
◊ Black stool
◊ Bloody stool
◊ Hemorrhoids
◊ Liver trouble
◊ Gall bladder problems
◊ Weight trouble

Habits

◊ Cigarettes
◊ Alcohol Abuse
◊ Coffee or Tea
◊ Exercise
◊ Drug abuse
◊ _____

Eye, Ear, Nose and Throat

◊ Eye strain
◊ Eye inflammation
◊ Vision problems
◊ Ear pain
◊ Ear discharge
◊ Hearing loss
◊ Nose pain
◊ Nose bleeding
◊ Nose discharge
◊ Difficult breathing through nose
◊ Sore gums
◊ Sore throat
◊ Hoarseness
◊ Difficult speech
◊ Sinus
◊ Allergy
◊ Jaw pain

ARE YOU PREGNANT?

YES ***NO***

Patient's Signature:_____

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~***DO NOT WRITE BELOW THIS LINE***~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

_____

_____

_____

_____

Patient accepted? YES NO Doctor's Signature _____
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Health History

Patient_____ Date_____

What treatment have you already received for your condition? Medications Surgery Physical Therapy
Chiropractic Services None Other

Name and address of other doctor(s) who have treated you for your condition_____

Date of last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____
Spinal Exam_____ Chest X-Ray_____ Urine Test_____
Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

Place a circle "YES" or "NO" to indicate if you have had any of the following:

AIDS/HIV	YES	NO	Chicken Pox	YES	NO	Liver Disease	YES	NO	Rheumatoid Arthritis	YES	NO
Alcoholism	YES	NO	Diabetes	YES	NO	Measles	YES	NO	Rheumatic Fever	YES	NO
Allergy Shots	YES	NO	Emphysema	YES	NO	Migraine Headaches	YES	NO	Scarlet Fever	YES	NO
Anemia	YES	NO	Epilepsy	YES	NO	Miscarriage	YES	NO	Stroke	YES	NO
Anorexia	YES	NO	Fractures	YES	NO	Mononucleosis	YES	NO	Suicide Attempt	YES	NO
Appendicitis	YES	NO	Glaucoma	YES	NO	Multiple Sclerosis	YES	No	Thyroid Problems	YES	NO
Arthritis	YES	NO	Goiter	YES	NO	Mumps	YES	NO	Tonsillitis	YES	NO
Asthma	YES	NO	Gonorrhea	YES	NO	Osteoporosis	YES	NO	Tuberculosis	YES	NO
Bleeding Disorders	YES	NO	Gout	YES	NO	Pacemaker	YES	NO	Tumors,Growth	YES	NO
Breast lump	YES	NO	Heart Disease	YES	NO	Parkinson's Disease	YES	NO	Typhoid Fever	YES	NO
Bronchitis	YES	NO	Hepatitis	YES	NO	Pinched Nerve	YES	NO	Ulcers	YES	NO
Bulimia	YES	NO	Hernia	YES	NO	Pneumonia	YES	NO	Vaginal Infections	YES	NO
Cancer	YES	NO	Herniated Disk	YES	NO	Polio	YES	NO	Venereal Disease	YES	NO
Cataracts	YES	NO	Herpes	YES	NO	Prostate Problem	YES	NO	Whooping Cough	YES	NO
Chemical Dependency	YES	NO	High Cholesterol	YES	NO	Prosthesis	YES	NO	OTHER_____		
			Kidney Disease	YES	NO				ARE YOU PREGNANT?	YES	NO
									DUE DATE_____		

Exercise	Work Activity
None	Sitting
Moderate	Standing
Daily	Light Labor
Heavy	Heavy Labor

Habits

Smoking Packs/Day_____

Alcohol Drinks/Day_____

Coffee/Caffeine drinks Cups/day_____

High Stress Level Reason_____

Injuries/Surgeries	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Auto Accidents		

Medications _____

Pharmacy Name _____

Pharmacy Phone (___)_____

Allergies _____

Vitamins/Herbs/Minerals _____

USE BACK OF PAGE IF NEEDED