Healthy Body Acupuncture
Consultation Form

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

PATIENT INFORMATION

Name _____ Date _____ Social Security # _____
Home Address _____
City _____ State _____ Zip _____
Home Phone _____ E-mail _____ Work Phone _____
Occupation _____ Person Responsible for your account _____
Emergency Contact _____ Phone _____
Who should we thank for referring you to this office? _____

Sex: ❑ Male ❑ Female ❑ Trans ___MTF ___FTM Height _____ Weight _____ Birth date _____ Age _____
Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Partnered Number of children _____
Have you received acupuncture therapy before? ❑ Yes ❑ No
When? _____ With whom? _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____ Phone _____
Address of Insurance Company _____
Who is the primary insured? _____ Birth Date _____
Identification # _____ Policy # _____ Group # _____
Date Policy Begins _____ Total Yearly Deductible Individual $ _____ Family $ _____
Deductible Met to Date (Approx.) $ _____

SECONDAY INSURANCE INFORMATION

Insurance Company _____ Phone _____
Address of Insurance Company _____
Who is the secondary insured? _____ Birth Date _____
Identification # _____ Policy # _____ Group # _____
Date Policy Begins _____ Total Yearly Deductible Individual $ _____ Family $ _____
Deductible Met to Date (Approx.) $ _____

PRIMARY PHYSICIAN

Name _____ Phone _____
Address of Primary Physician _____

Assign and Release: I hereby authorize payment of medical benefits to Healthy Body Acupuncture for the services rendered to me during this and subsequent visits. I also authorize the release of any information necessary to process medical claims

_____
Patient Signature and Date

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	❑	❑	_____
Rheumatic Fever	❑	❑	_____	Emotional Disorders	❑	❑	_____
Infectious Diseases	❑	❑	_____	Tuberculosis	❑	❑	_____

Sexually Transmitted Diseases: ❑ Gonorrhea ❑ Syphilis ❑ HIV ❑ HPV ❑ Chlamydia ❑ Herpes Date _____

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

Medicine	*Dosage*	*Reason*	*How long*	*Prescribed by*	*Date of last checkup*

Check the box if any of the following statements is true?

❑ I have known allergies
❑ I have a pacemaker
❑ I am taking Coumadin/warfarin
❑ I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs)

Please indicate the use and frequency of the following:

	Yes	***No***	***How much***		***Yes***	***No***	***How much***
Coffee/black tea	❑	❑	_____	Tobacco	❑	❑	_____
Non-medical drugs	❑	❑	_____	Soda pop	❑	❑	_____

FOR WOMEN

Age of 1st period (menarche) _____
Age of last period (menopause) _____
Number of days between periods _____
Number of days of flow _____
Color of flow _____
Clots? ❑ Yes ❑ No Color _____

Are you pregnant? ❑ Yes ❑ No # of pregnancies _____
# of live births _____ # of Abortions _____ # of Miscarriages _____
Date of last: Gynecologic exam _____ Pap Smear _____
Mammogram _____ Bone Density Scan _____
Results _____
_____

Average number of pads you use per day: 1st day _____ 2nd day _____ 3rd day _____ 4th day _____ + days _____
Have you ever been diagnosed with: ❑ Fibroids ❑ Fibrocystic breasts ❑ Endometriosis ❑ Ovarian Cysts ❑ PID Other _____
Location of Pain: ❑ Lower abdomen ❑ Lower back ❑ Thighs ❑ Other_____

Nature of Pain (please indicate before, during or after menses)

Cramping _____ Stabbing _____
Burning _____ Aching _____
Dull _____ Bloating _____
Consistent _____ Intermittent _____
Bearing down sensation _____

Other symptoms related to menses

❑ Discharge	❑ Vaginal dryness	❑ Headache
❑ Nausea	❑ Constipation	❑ Diarrhea
❑ Swollen breasts	❑ Mood swings	❑ Ravenous appetite
❑ Poor appetite	❑ Hot flashes	❑ Night Seats
❑ Increased libido	❑ Decreased libido	❑ Insomnia

FOR MEN

Date of last prostate check up _____ PSA results _____ Manual prostate exam results _____
Lab results _____
Frequency of Urination: daytime _____ nighttime _____ Color of urine: ❑ clear ❑ murky odor: _____

Symptoms related to prostate

❑ Prostate problems	❑ Delayed stream	❑ Dribbling	❑ Incontinence	❑ Retention of urine
❑ Rectal dysfunction	❑ Increased libido	❑ Decreased libido	❑ Premature ejaculation	❑ Impotence
❑ Back pain	❑ Groin pain	❑ Testicular pain	Other _____	

SYMPTOM SURVERY (FOR EVERYONE)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
no mark () = never experience check mark (✓) = sometimes experience plus sign (+) = frequently experience

__ lack of appetite
__ excessive appetite
__ loose stool or diarrhea
__ digestive problems, indigestion
__ vomiting
__ belching, burping
__ heartburn, reflux
__ feeling the retention of food in the stomach
__ tendency to become obsessive in work, relationships …
_____
__ insomnia, difficulty sleeping
__ heart palpitations
__ heart palpitations
__ cold hands and feet
__ nightmares
__ mentally restless
__ laughing for no reason
__ angina pains

__ abdominal pain
__ chest pain
__ sciatic pain
__ headaches
__ pain or coldness in the genital area
_____
__ cough
__ shortness of breath
__ decrease sense of smell
__ nasal problems
__ skin problems
__ feeling of claustrophobia
__ bronchitis
__ colitis or diverticulitis
__ constipation
__ hemorrhoids
__ recent use of antibiotics
__ eye problems
__ jaundice(yellowish eyes/skin)

__ difficulty digesting oily foods
__ gall stones
__ light colored stool
__ soft or brittle nails
__ easily angered or agitated
__ difficulty in making plans or decisions
__ spasms or twitching of muscles
_____
__ low back pain
__ knee problems
__ hearing impairment
__ ear ringing
__ kidney stones
__ decreased sex drive
__ hair loss
__ urinary problems
__ fatigue
__ edema

__ blood in stool
__ black tarry stool
__ easily bruised
__ difficult to stop bleeding
__ asthma
__ tendency to catch colds easily
__ intolerance to weather changes
__ allergies
__ hay fever
__ dizziness
__ tendency to faint easily
__ high cholesterol levels
__ sudden weight loss

What are the main problems for which you are seeking treatment?

_____
_____
_____
_____

What other forms of treatment have you sought?

_____
_____
_____
_____

List any other health problems you now have.

_____
_____
_____
_____

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

_____
_____
_____
_____

List any accidents, surgeries or hospitalizations (include date)

_____
_____
_____
_____

Lab Results (please include copies)

_____
_____
_____

Clinical Notes

(Intern's Use)

HPI:

❑ Onset ❑ Location ❑ Duration ❑ Characteristics
❑ Aggrevate/allev ❑ Related factors ❑ Treatment ❑ Significance

How do you FEEL about the following areas of your life?
Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Your Comments
Significant Other	❑	❑	❑	❑	❑	_____
Family	❑	❑	❑	❑	❑	_____
Diet	❑	❑	❑	❑	❑	_____
Sex	❑	❑	❑	❑	❑	_____
Self	❑	❑	❑	❑	❑	_____
Work	❑	❑	❑	❑	❑	_____
Exercise	❑	❑	❑	❑	❑	_____
Spiritually	❑	❑	❑	❑	❑	_____