Acupuncture Works LLC

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Licensed Acupuncturist

Patient Information Sheet – pg. 1

CONFIDENTIAL
Important: Complete this form as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Full Legal Name			**Preferred Name/Nickname**
Gender M ☐ F ☐	**Date of Birth**	**Age**	**Marital Status** Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Address	**City**	**State**	**Zip**

Daytime Phone # (home □ work □ cell □) *Check One	**Alternate Phone # (home □ work □ cell □) *Check One**
Emergency Contact & Relationship	**Phone Numbers of Emergency Contact** **Primary** **Alternate**

Check Health Insurance Coverage: NONE □ HEALTH □ MOTOR VEHICLE □ WORKERS' COMP □ OTHER □

If insurance is to be billed by our office please read, sign and date the following:

Assignment of Benefits/Release of Records/Payment Agreement

I hereby direct and instruct my insurance company to make payment directly to Michelle Blackwood for medical claims submitted on my behalf for medically necessary treatment. I hereby authorize Michelle Blackwood to furnish any and all records, reports or information as may be requested in reference to my case and treatment, to any and all treating physicians, attorneys or insurance companies. I understand that my insurance contract is an agreement between the insurance company and myself. I acknowledge that your office is willing to prepare the necessary reports and assist me in collecting from the insurance company that which is due to you for my medically necessary care and treatment. I agree and acknowledge that I am ultimately responsible to you for payment of any balance due, including unpaid deductible and/or unpaid percentage amounts due to you according to my policy coverage, in the event you are unable to collect from my insurance carrier or attorney in the case where you are holding an attorney lien on my behalf.

Patient Signature ____ Date ____________________

Whom may I thank for referring you? Friend/Family/Doctor (*Name*)____

Yellow Pages ☐ Health Insurance Co ☐ Google ☐ AOL ☐ Yahoo ☐ Other ________________________________

Would you like to receive announcements/updates via email? Y ☐ N ☐

** *Please be assured that your email address will only be used by our office for the above intended purposes and will not be sold to other companies or individuals.*

Email:____

Patient Name____ Date: _________________

Personal Health History – pg. 2

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Major Complaint(s), in order of importance to you:

	Mild	Moderate	Severe
____________________	☐	☐	☐
____________________	☐	☐	☐
____________________	☐	☐	☐

Major **SURGERY/HOSPITALIZATIONS:** ____________________

Major **INJURIES/ACCIDENTS:** ____________________

Height_______ Weight_______ Have you lost or gained weight in the past year? How much gained______? Lost______?

Do you participate in a regular **EXERCISE** program? What activities and how often per week? ____________________

Please list your **HOBBIES/INTERSTS** ____________________

How many hours of **SLEEP** per evening?______ Are you satisfied with your sleep? _______ If not, why? ____________________

HABITS (check those habits that apply and note typical quantity consumed)

☐ Tobacco_______ ☐ Coffee_______ ☐ Tea_______ ☐ Soda_______ ☐ Alcohol_______ ☐ Recreational Drugs______

ALLERGIES: Medications, Seasonal, Environmental, Food (Please List) ____________________

OCCUPATIONAL CONCERNS: Frequent Computer/Typing/Mouse use____ Toxic Substances____ Heavy Lifting____ High Stress Loads____ Unusual Hours-i.e. Swing/Graveyard Shifts____ Other______________________________________

MEDICATIONS (Please list *Name *Dosage and *Purpose of all prescriptions, nutritional supplements and medicines that you may only use on occasion) ____________________

Patient Name____ Date: ________________

PERSONAL & FAMILY HEALTH HISTORY

Please "X" all conditions that you or your family members currently have. Indicate with a "P" if condition is one you or family members have had in the past. Leave blank those spaces that do not apply.

	Self	Mother	Father	Aunt/Uncle	Brother/Sister	Children
AIDS						
Alocholism						
Anemia						
Arteriosclerosis						
Arthritis						
Asthma						
Cancer						
Degenerative Disc Disease						
Diabetes						
Digestive Diseases						
Eczema						
Emphysema						
Epilepsy						
Headaches						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Hypothyroid						
Insomnia						
Kidney Disease						
Low Blood Pressure						
Liver Disease						
Mental Illness						
Migraines						
Miscarriage						
Multiple sclerosis						
Nervousness						
Obesity						
Pacemaker						
Pneumonia						
Psoriasis						
Scoliosis						
Stroke						
Sinusitis						
Other__________________						

Patient Name____ Date: ________________

Personal Health History – pg. 3

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FEMALES: Pregnant Yes □ No □ Form of birth control___________________ Last period_______________

Last PAP test________________ Age when period started______ Age stopped_______ No. Pregnancies_______

No. Vaginal Deliveries_______ No. Miscarriages________ No. Caesareans_________ No. Abortions__________

Do you experience: □ Heavy bleeding □Vaginal dryness □Vaginal discharge □ Clotting □ Menstrual pain

□Water retention □ Low backache □ Mood changes □ Irregular Periods □ Painful breast □ Hot flashes

SYMPTOMS - For each symptom you currently have rate severity from 1-5 (5 at its worst). Leave blank if N/A.

___ **Irritability**
___ Depression
___ Headaches/migraines
___ Visual problems
___ Red eyes
___ Dry/itchy eyes
___ Spots in front of eyes
___ Blurred vision
___ Feeling of lump in throat
___ Clenching of teeth at night
___ Muscle cramping
___ Muscle twitching
___ Joints feel tight/stiff
___ Cold hands/feet
___ Gas/belching
___ Soft/brittle nails
___ Bloating
___ Craving/avoiding sour foods
___ Abdominal pain
___ Indigestion/heartburn
___ **Heart palpitations**
___ Chest pain
___ Dizziness
___ Insomnia
___ Easily startled
___ Restlessness/agitation
___ Anxiety

___ Breathlessness
___ Vivid dreams
___ Dreams are bothersome
___ Lack of joy in life
___ Laughing for no reason
___ Craving/avoiding bitter foods
___ **Urinary problems**
___ Frequent urination
___ Incontinence
___ Weakness/pain in lower back
___ Aching bones
___ Feel cold easily
___ Low sexual desire
___ Poor memory
___ Loss of hair
___ Hearing problems
___ Excess sexual desire
___ Ringing in ears
___ Craving/avoiding salty food
___ **Dry cough**
___ Cough with sputum
___ Nasal discharge
___ Poor sense of smell
___ Nose bleeds
___ Itchy, red or painful throat
___ Dry mouth
___ Skin rashes

___ Itchy skin
___ Grief, sadness
___ Shortness of breath
___ Allergies
___ Craving/avoiding spicy food
___ **Heaviness anywhere in body**
___ Fatigue
___ Hard to get up in the morning
___ Edema (swelling)
___ Muscles feel tired often
___ Easy bruising and bleeding
___ Bad breath
___ Low appetite
___ Snacking
___ Tendency towards hypoglycemia
___ Difficulty digesting oily foods
___ Hemorrhoids
___ Nausea
___ Vomiting
___ Diarrhea
___ Constipation
___ Overthinking
___ Tendency to become obsessive
___ Craving/avoiding sweets
___ Low resistance to colds or flu
___ Low physical stamina
___ Mild fever comes and goes