

PATIENT INFORMATION FORM

(Please print.)

Today's Date:

CONTACT INFORMATION

First Name:

Middle Initial:

Last Name:

Relationship Status:

Single Married Divorced/Separated Widowed

Sex:

M F

Birth Date:

/ /

Age:

Street Address:

P.O. Box:

City:

State:

Zip Code:

Home Phone: ()

Occupation:

Employer:

Work Phone : ()

Cell Phone:

()

Fax Number:

()

Email Address:

What is the best way to contact you?

Home Phone Cell Phone Work Phone Email

Primary Care Physician (PCP) Name:

PCP Phone: ()

PCP Address:

How did you find out about Healing Hands Acupuncture and Herbal Clinic, LLC?

Dr. _____ Friends/Family Magazine Internet

Insurance Plan Yellow Pages Other (Please Specify) _____

Emergency Contact Name:

Emergency Contact Phone: ()

Relationship to the Patient:

Have you ever had acupuncture prior to this visit?

Yes No

If yes, with whom:

INSURANCE INFORMATION

(Only needed if your insurance covers acupuncture.)

Name of Insurance Company:

Name of the Insured:

Social Security Number:

Group Number:

Policy Number:

Patient's relationship to subscriber:

Self

Spouse

Child

Other

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Healing Hands Acupuncture and Herbal Clinic, LLC or my insurance company to release any information required to process my claims.

Patient/Guardian Signature

Date

GENERAL HEALTH INFORMATION

I. Chief Complaints

Please list in order of importance the health conditions that prompted you to seek treatment today:

II. Past Medical History and Family History (Check all that apply.)

MEDICAL CONDITIONS	DATE DIAGNOSED	FAMILY HISTORY	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> High Cholesterol		<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Thyroid Disease (Specify)		<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Cancer (Specify)		<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Asthma		<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Migraine		<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Seizures		<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Stroke		<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Heart Disease		<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Mental Illness (Specify)		<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Hepatitis (Circle) A / B / C / D		<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> HIV /AIDS		<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Sexually Transmitted Diseases (Circle) Chlamydia / Gonorrhea / HPV / Syphilis / Herpes		<input type="checkbox"/> yes	<input type="checkbox"/> no

List all major surgeries or hospitalizations that you have had:

Surgeries or Hospitalization	Date	Reason for Surgery or Hospitalization
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III. Medications

List all the medications and supplements that you are currently taking including: prescriptions, herbs, vitamins, supplements, and/or over-the-counter medication you take on a regular basis, along with dosage and brand if known:

Name	Dosage	Reason for Taking It
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List any known allergies you have to medication, chemicals, and/or foods:

IV. Lifestyle

Nutrition:

1. Do you follow a special diet? yes no

If yes, specify _____

2. What do you eat on a "typical day?"

a. Breakfast

b. Lunch

c. Dinner

d. Snacks

e. Foods Craved

Social History:

1. How much of the following do you consume per day?

Coffee _____ Tea _____ Soft Drinks _____

Water _____ Alcohol _____ Cigarettes _____

2. Do you use recreational drugs? yes no If yes, what and how many times per week? _____

3. Have you ever had or have a problem with alcohol or alcoholism? yes no

4. Have you ever had or have a problem with dependency of prescription drugs? yes no

5. Do you have known history of exposure to toxic substances? yes no

If yes, list what symptoms you have experienced and when you first started noticing them:

6. How many times per week do you exercise? _____

7. Describe the type of exercise that you do:

Emotions:

1. How do you generally feel emotionally?

2. Do you have: Panic Attacks Anxiety Anger
 Difficulty Concentrating Nervousness Poor Memory

3. How do you react to stress?

4. How many hours of sleep do you get per night? _____

5. Do you have trouble falling asleep and/or staying asleep? _____

6. Do you experience disturbed or frequent dreaming? _____

Skin and Hair:

Do you have: Dry Skin Skin Rashes Hair Loss Dry Hair
 Eczema Hives Premature Graying Acne Psoriasis

Respiratory, Eyes, Ear Nose, Throat, and Head:

Do you have: Runny Nose Cough Coughing Blood Sore Throat
 Congestion Shortness of Breath Frequent Colds Nose Bleeds Sinusitis
 Floaters Pain Inhaling Dizziness Poor Vision Cold Sores
 Acid Reflux Ringing in the Ears Dry Eyes
 Frequent Headaches/Migraines, describe: _____

Cardiovascular:

Do you have: Chest Pain Palpitations Cold Hands and Feet
 Varicose Veins Neuropathy Low Blood Pressure Edema

Gastrointestinal:

1. Do you have: Belching Nausea Vomiting Vomiting of Blood
 Ulcers Heartburn Hernia Bloating Diarrhea
 Gas Hemorrhoids Constipation Severe Abdominal Pains

2. How many bowel movements do you have a day? _____

Genital/Urinary:

- 1. Urination: How many times per day? _____ Color: Pale Yellow Dark Yellow Tinges of Red
- 2. Do you have: Painful Urination Urgent Urination Scanty Urination
 Kidney Stones Unable to Hold Urine Genital Sores Frequent Night Urination
 Prone to and/or Frequent Urinary Tract Infections Prone to and/or Frequent Yeast Infections

Muscle, Joints, and Bones:

- 1. Do you experience pain or tightness? yes no If yes, where? _____
- 2. The pain is: Sharp Aching Numb Deep Burning Dull
 Superficial Tingling Worse with Heat Better with Heat
 Worse with Cold Better with Cold Worse in the AM
 Worse in the PM Worse with Movement Better with Movement
- 3. Do you have: Swollen Joints Arthritis/Joint Pain Tendonitis Repetitive Strain
 Rheumatism Bone pain Muscle cramping Carpal Tunnel Syndrome

V. For Women Only

<p>Age of first period: _____</p> <p>Age of last period if you have gone through menopause: _____</p> <p>Date of last pap smear: _____ Result: _____</p> <p>Any history of abnormal pap smear? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>If yes, when and what was the treatment given?</p> <p>_____</p> <p>Date of last period: _____</p> <p>Are you pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure</p> <p>Please indicate the number of occurrences:</p> <p><input type="checkbox"/> Pregnancies _____ <input type="checkbox"/> Live Births _____</p> <p><input type="checkbox"/> Miscarriages _____ <input type="checkbox"/> Abortions _____</p>	<p>Is your menstrual cycle regular? <input type="checkbox"/> yes <input type="checkbox"/> No</p> <p>Average number of days of flow: _____</p> <p>The flow is: <input type="checkbox"/> Normal <input type="checkbox"/> Heavy <input type="checkbox"/> Light</p> <p>The color is: <input type="checkbox"/> Normal <input type="checkbox"/> Dark <input type="checkbox"/> Bright Red <input type="checkbox"/> Pale Red <input type="checkbox"/> Light Brown</p> <p>Do you experience any of the following menstruation related signs/symptoms?</p> <p><input type="checkbox"/> Cramps <input type="checkbox"/> PMS <input type="checkbox"/> Blood Clots <input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Mood Swings <input type="checkbox"/> Breast Distention and/or Pain</p> <p><input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Bloating</p> <p><input type="checkbox"/> Bleeding Between Periods</p>
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VI. For Men Only

Do you have any bothersome urinary symptoms? yes no

If yes, describe:

How many times a night do you get up to urinate? _____

Have you ever been diagnosed with Prostate Cancer? yes no

Last PSA date: _____ Result: _____

Do you have: Erectile Dysfunction Pain in the Testicles Pain in the Testicles Impotence
 Coldness and/or Numbness in the Genitalia Premature Ejaculation

To what extent do these conditions interfere with your daily activities?

Have you sought medical intervention for these problems? yes no

If yes, what and when?

Were these treatments successful? yes no

Thank you for choosing Healing Hands Acupuncture and Herbal Clinic, LLC.

Sincerely,

Andrea Perullo, L.Ac., M.S.

