Welcome!

New Patient Information

WellCareAcupuncture.com

Patient Information

First Name:		
Middle Name:		
Last Name:		
Address:		
City:	State:	Zip:
Home #:	Work #:	Cell #:
Gender: ☐ M ☐ F	Date of Birth:	Age:
☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Widowed ☐ Divorced		
# Children:	Ages:	
E-Mail:	☐ Yes ☐ No	Would you like promo and health info from WellCare
Occupation:		Employer:

How Did You Find Us?

Referral Name:	Website Name:
Mailer #:	Referral Directory:
Other:	

Financial Responsible Party

☐ Self and ☐ Spouse Name:
☐ Health Insurance:
☐ Worker's Comp.:
☐ Personal Injury:
☐ Other (Specify):

Emergency Information

Name:	
Relationship:	
Cell Phone:	
Work Phone:	Ext.:
Home Phone:	

Patient Insurance Information

Primary Insurance Carrier:		
Address:		
City:	State:	Zip:
Identification / Policy #:	Group #:	
Insured's Last Name:	First Name:	
Insured Date of Birth:	Insured S.S. #:	
Secondary Insurance Carrier (if applicable):		
Address:		
City:	State:	Zip:
Identification / Policy #:	Group #:	
Insured's Last Name:	First Name:	
Insured Date of Birth:	Insured S.S. #:	

PATIENT CONDITION

What is your main health concern?

When did your symptoms recently appear?

Is this condition: ☐ getting worse ☐ staying same ☐ come and go

Has this condition occur before? ☐ Yes ☐ No

If Yes, when was first onset?

How often do you have the symptoms?
_____ times per ☐ day ☐ week ☐ month
☐ Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching
☐ Shooting ☐ Burning ☐ Tingling ☐ Tightness ☐ Stiffness ☐ Swelling
☐ Other:

What aggravates symptoms?_____
What relieves symptoms?_____
Does weather affect it? ☐ Yes ☐ No

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
☐ Other:

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing
☐ Walking ☐ Bending ☐ Lying Down ☐ Other:

What treatment have you already tried for this condition? ☐ None
☐ MD / allopathic / Western medicine ☐ Surgery ☐ Medications ☐ Chiropractic
☐ Injections ☐ Physical Therapy ☐ Naturopathic ☐ Other:

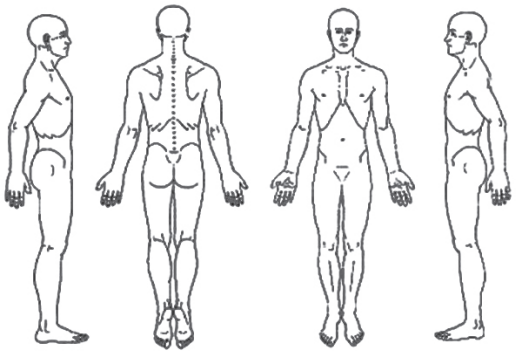
Have you had acupuncture before? ☐ Yes ☐ No. If yes, why?_____
Approximate date of last visit: Did it help?

Name and phone of other practitioners who have treated you for your condition:

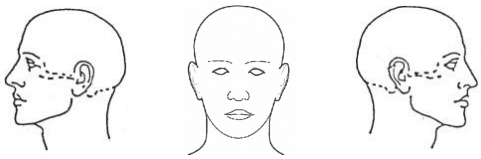
May we contact your doctor ☐ Yes ☐ No

What other health issues do you have? (List any diagnosis given):

1. Circle pain area
2. Mark pain intensity level from 1 (least pain) to 10 (severe pain)



Right L - Back - R R - Front - L Left



Left R - Front - L Right

Date of Last Physical Exam: Blood Test: Urine Test: Spinal Exam:
Spinal X-Ray: Chest X-Ray: Dental X-Ray: MRI/CT-Scan:

MEDICAL HISTORY

Check ✔ any of the following conditions you currently have or have had in the past:

☐ Allergies
☐ Anemia
☐ Aneurysm
☐ Appendicitis
☐ Arteriosclerosis
☐ Arthritis
☐ Rheumatoid ☐ Osteo
☐ Asthma
☐ Bleeding Disorders
☐ Breast Lump
☐ Bronchitis
☐ Cancer`
☐ Chicken Pox
☐ Chronic Fatigue Syndrome
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Epstein Barr Virus
☐ Fibromyalgia
☐ Glaucoma
☐ Goiter
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ B ☐ C
☐ Herpes Zoster ("shingles")
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disease
☐ Liver Disease
☐ Measles
☐ Migraine Headaches
☐ Miscarriage
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Mumps
☐ Osteoporosis
☐ Pacemaker
☐ Parkinson's Disease
☐ Pinched Nerve
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Prostate Problem
☐ Prosthesis
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Stroke
☐ Seizures
☐ Thyroid Disorders
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors/Growths
☐ Typhoid Fever
☐ Ulcers
☐ Vaginal Infections
☐ Whooping Cough
☐ Other (specify)
_____
_____
_____
_____
_____
_____
_____

CONTAGIOUS HISTORY

Have you had or do you have a contagious illness that may require special procedures to protect our staff and others

☐ Hepatitis ☐ Tuberculosis ☐ Venereal Disease
☐ AIDS ☐ Herpes ☐ MRSA
☐ Other: _____

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Thyroid
Mother:	☐	☐	☐	☐	☐
Father:	☐	☐	☐	☐	☐
Sibling:	☐	☐	☐	☐	☐

PATIENT NAME: D.O.B.:

SYMPTOMS

Check ✔ if YES to any of the following symptoms or conditions <u>in past 6 months:</u>

YOUR LIFESTYLE

☐ Alcohol
☐ Tobacco
☐ Marijuana
☐ Drugs
☐ Stress
☐ Occupational Hazards:
☐ Regular Exercise
Type: _____ Frequency: _____

GENERAL SYMPTOMS

☐ Poor Appetite
☐ Heavy Appetite
☐ Prefer Cold Drinks
☐ Prefer Hot Drinks
☐ Weight Gain or Loss
☐ Poor Sleep
☐ Heavy Sleep
☐ Dream Disturbed Sleep
☐ Fatigue
☐ Lack of Strength
☐ Bodily Heaviness
☐ Cold Hands or Feet
☐ Poor Circulation
☐ Shortness of Breath
☐ Fever
☐ Chills
☐ Night Sweats
☐ Sweat Easily
☐ Muscle Cramps
☐ Vertigo or Dizziness
☐ Bleed or Bruise easily
☐ Peculiar Taste (describe)
_____
_____
_____

HEAD / EYES / EARS / NOSE / THROAT

☐ Glasses
☐ Eye Strain
☐ Eye Pain
☐ Red Eyes
☐ Itchy Eyes
☐ Spots in Eyes
☐ Poor Vision
☐ Blurry Vision
☐ Night Blindness
☐ Glaucoma
☐ Cataracts
☐ Teeth Problems
☐ Grinding Teeth
☐ TMJ
☐ Facial Pain
☐ Gum Problems
☐ Sores on Lips or Tongue
☐ Dry Mouth
☐ Excessive Saliva
☐ Sinus Problems
☐ Excessive Phlegm
☐ Color of Phlegm
_____
☐ Sore Throat
☐ Lumps in Throat
☐ Enlarged Thyroid
☐ Nose Bleeds
☐ Ringing in Ears
☐ Poor Hearing
☐ Earaches
☐ Headaches
☐ Concussions
☐ Other Head / Neck Problems
_____
_____
_____

RESPIRATORY

☐ Tightness in Chest
☐ Cough
☐ Bronchitis
Productive? _____
☐ Pneumonia
Wet or Dry? _____
☐ Shortness of Breath
☐ Color of Phlegm
☐ Asthma / Wheezing
_____

CARDIOVASCULAR

☐ High Blood Pressure
☐ Blood Clots
☐ Low Blood Pressure
☐ Fainting
☐ Chest Pain
☐ Difficulty Breathing
☐ Tachycardia
☐ Irregular Heartbeat
☐ Palpitations

GASTROINTESTINAL

☐ Nausea
☐ Vomiting
☐ Acid Regurgitation
☐ Gas
☐ Hiccup
☐ Bloating
☐ Bad Breath
☐ Diarrhea
☐ Constipation
☐ Laxative Use
☐ Black Stools
☐ Bloody Stools
☐ Mucous in Stools
☐ Intestinal Pain/Cramp
☐ Itchy Anus
☐ Burning Anus
☐ Rectal Pain
☐ Hemorrhoid
☐ Anal Fissures
Frequency _____
Color _____
Texture/Form _____
Odor _____

MUSCULOSKELETAL

☐ Neck / Shoulder Pain
☐ Muscle Pain
☐ Upper Back Pain
☐ Lower Back Pain
☐ Joint Pain
☐ Rib Pain
☐ Limited Range of Motion
☐ Limited Use
☐ Other (describe)
_____

SKIN / HAIR

☐ Rashes
☐ Hives
☐ Eczema
☐ Psoriasis
☐ Dandruff
☐ Itching
☐ Change in Hair
☐ Fungal Infection
☐ Change in Skin Texture
☐ Other Hair / Skin Problems
_____
_____

NEUROPSYCHOLOGICAL

☐ Seizures
☐ Numbness
☐ Tics
☐ Poor Memory
☐ Depression
☐ Anxiety
☐ Irritability
☐ Easily Stressed
☐ Abuse Survivor
☐ Considered Suicide
☐ Seeing Therapist
☐ Other (specify)
_____
_____

GENITO-URINARY

☐ Pain on Urination
☐ Frequent Urination
☐ Urgent Urination
☐ Blood in Urine
☐ Unable to Hold Urine
☐ Incomplete Urination
☐ Venereal Disease
☐ Bedwetting
☐ Wake to Urinate
☐ Increased Libido
☐ Decreased Libido
☐ Kidney Stone
☐ Impotence
☐ Premature Ejaculation
☐ Nocturnal Emission

GYNECOLOGY

☐ Pregnant
☐ Age Menses Began
_____
☐ Length of Cycle
_____
☐ Nursing
☐ Duration of Flow
_____
☐ Irregular Periods
☐ Painful Periods
☐ PMS
☐ Birth Control Pill
☐ Vaginal Discharge
(color) _____
☐ Vaginal Sores
☐ Vaginal Odor
☐ Clots
☐ Breast Implant
☐ Breast Lumps
Pregnancies_____
Births_____
Premature Births_____
Age of Menopause_____
Date of Last PAP
_____/_____/_____
Date Last Period Began
_____/_____/_____

PATIENT NAME: D.O.B.:

Exercise

☐ None
☐ Moderate
☐ Daily
☐ Heavy

Work Activity

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

Habits

☐ Smoking — Packs / Day: _____
☐ Alcohol — Drinks / Week: _____
☐ Coffee / Caffeine Drinks — Cups / Day: _____
☐ High Stress — Reason: _____

Medications

_____
_____
_____
_____

Allergies

_____
_____
_____
_____

Vitamins / Herbs / Minerals

_____
_____
_____
_____

Injuries and Surgeries

List any injuries and /or surgeries you have had and their dates.

Fall	Date	Head Injury	Date	Broken Bone	Date	Dislocation	Date	Surgery	Date

Restricted Medical History

The following medical history information has additional restrictions placed upon its release to third parties, and will not be disclosed to others unless you explicitly authorize it or we are otherwise ordered by legal authorities to release it.

Check ✔ any of the following conditions you currently have or have had in the past:

Addictions: ☐ Yes ☐ No
If Yes, took what substance? _____
If you have stopped using this, when did you stop? _____

Alcoholism: ☐ Yes ☐ No
If Yes, how long? _____ Are you alcohol-free now? ☐ Yes ☐ No (If Yes, since when? _____)

Anorexia: ☐ Yes ☐ No
Bulimia: ☐ Yes ☐ No

Mental Health Disorder: ☐ Yes ☐ No
If Yes, please describe: _____

Suicide Attempt: ☐ Yes ☐ No
If Yes, how long ago? _____

Domestic Violence or Abuse Victim: ☐ Yes ☐ No

Your Health Care Goals

Although most people seek acupuncture as a last resort, they mainly have two goals:
Symptomatic relief of pain or discomfort (Relief Care) or finding and treating the root cause of their condition (Corrective Care). Those who understand how acupuncture works seek Holistic Comprehensive Care for optimum health which includes preventative care. After consultation, the doctor will recommend a treatment program based on your health care goals. Please indicate which level of care you desire.

☐ Relief Care: Symptomatic relief of pain or discomfort	☐ Corrective Care: Finding and treating the root cause of the condition	☐ Holistic Comprehensive Care: Achieve optimum health which include preventative care

I certify that I am the patient (or legal guardian) listed on Patient Information Form. I have read and understood the questionnaire on this 4-page form and certify it to be true and accurate to the best of my knowledge. I agree to notify this provider immediately whenever I have any changes to the Patient Information Form.

Patient Signature: _____ Date: _____

Parent or Legal Guardian (if applicable): _____ Date: _____

PATIENT NAME: D.O.B.: