

PATIENT INFORMATION

Today's Date: _____

Mr.
Mrs.
Ms.
Jr / Sr.

LAST NAME : _____ Middle: _____ First: _____

DOB: _____ Age: _____ Gender: M / F
Marriage Status: Single / Married / Divorced / Widowed

Address: _____ Apt. _____

City: _____ State: _____ Zip: _____

Phone: _____ Home: _____ Cell: _____

Email: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Who referred you? _____

INSURANCE COMPANY: _____

POLICY NUMBER: _____

7. Do you have any infectious diseases? Y N If yes, please identify: _____

8. Family History:

Check those applicable:

	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Children</u>
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

9. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

10. **Blood Pressure:** What is your most recent blood pressure reading? _____ / _____

When was this reading taken? _____

11. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles
ChickenPox

12. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Other immunizations: _____

13. Hospitalizations and Surgeries:

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

15. Emotional (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension

16. Energy and Immunity (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

17. Head, Eye, Ear, Nose, and Throat (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness
Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems
Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

18. Respiratory (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema
Persistent Cough Pleurisy Asthma Tuberculosis
Shortness of Breath Other Respiratory Problems: _____

19. Cardiovascular (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure
Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

20. Gastrointestinal (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas

Heartburn Belching Gall Bladder Disease Liver Disease Hepatitis B or C
Hemorrhoids Abdominal Pain

21. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination
HeavyFlow Kidney Stones Impaired Urination Blood in Urine Frequent
Urination at Night

22. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow
Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles
Menopausal Symptoms Difficulty Conceiving Painful Periods

23. **Menstrual/Birthing History:**

1. Age of First Menses: _____ 4. Birth Control Type: _____ 7. # of Abortions: _____
2. # of Days of Menses: _____ 5. # of Pregnancies: _____ 8. # of Live Births: _____
3. Length of Cycle: _____ 6. # of Miscarriages: _____

24. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

25. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain
Mid Back Pain Low Back Pain Leg Pain Joint Pain (if so, where?): _____

26. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

27. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

28. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____

29. Lifestyle:

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Exercise routine: _____

c. Spiritual practice: _____

d. How many hours per night do you sleep? _____ Do you wake rested? Y N

e. Level of education completed: High School Bachelors Masters Doctorate
Other

f. Occupation: _____ Employer: _____
Hours/Week: _____
Do you enjoy work? Y/N Why/Why not? _____

g. Nicotine/Alcohol/Caffeine Use: _____

h. Have you experienced any major traumas? Y N Explain:

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

j. Television habits: _____ Reading habits: _____

k. Interests and hobbies: _____

How did you hear about us? _____
Would you like to receive our email newsletter? _____

Optimal Results Acupuncture

Financial Policy Statement

Optimal Results Acupuncture will bill your insurance carrier out of a courtesy and as a convenience for you. However, you are ultimately responsible for payment for the services you receive. If your insurance company does not remit payment within **60 days**, the balance will be due in full from you. If payment for services is made directly to you, you must remit the payment to our clinic. If your insurance company remits only a percentage of the total balance due, you will be responsible for the remainder of the balance. **Copays are always due at the time of service.**

Authorization for Disclosure of Medical Records

I authorize Optimal Results Acupuncture to release copies of the acupuncture record and billing statements to my insurance company for the purpose of billing for the services rendered.

Cancellation/No Show Policy

The appointments made represent time set aside specifically for you. All cancellations should be made **at least 24 hours prior to the scheduled visit** except emergency situations. Patients who cancel or are a "no show" on three separate occasions without good cause will be allowed to schedule additional appointments only at the discretion of the treating acupuncturist.

Optimal Results Acupuncture reserves the right to charge you \$40 for any appointments that are canceled with less than 24 hours notice.

I understand and agree to the Financial Policy Statement, Authorization for Disclosure of Medical Records, and Cancellation/No show Policy as described above:

Patient Signature _____ Date _____