LA VERNE ACUPUNCTURE - INTAKE

Patient Name________________________________ Birth date ____/____/____ M F circle one

Address__________________________ City____________ State_______ Zip__________

Phone (Home)(___)______________ (Work)(___)______________ (Cell)(___)______________

E-mail ________________________________Referred by________________________

Employer________________________ Occupation________________________

Reason for seeking treatment ____

Date symptom(s) started ____

Do you have medical insurance that covers acupuncture? Yes________ No________

If yes, please provide insurance card so that we may verify coverage.

Circle area(s) of current pain: Head, Neck, Jaw, Shoulder, Arm, Elbow, Wrist, Hand, Upper Back, Lower Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other________________

Circle your pain level: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

How often are your symptoms present? Constantly__ Frequently__ Intermittently__ Occasionally___

Describe your current health condition? Good___ Fair___ Poor___ Chronically Ill___

Can you perform all your daily activities? Yes, all activities___ Some activities___ Not at all___

Are you currently under the care of a physician? No_____ Yes_____

What treatments, if any, have you received for the condition you've come to us for? (Surgery, medications, chiropractic, etc.)____

____

Please check the appropriate boxes:

Past / Present

____ ____ Alcohol/tobacco/drug Dependence
____ ____ Abnormal menstruation
____ ____ Allergies
____ ____ Angina
____ ____ Arthritis/rheumatoid arthritis
____ ____ Artificial joints
____ ____ Asthma
____ ____ Blood disorder
____ ____ Breast lumps
____ ____ Cancer/tumor
____ ____ Convulsions/seizures
____ ____ Diabetes
____ ____ Diarrhea/constipation
____ ____ Excessive thirst
____ ____ Fainting or dizziness
____ ____ Rapid weight gain/loss

Past / Present

____ ____ Frequent urination
____ ____ Headache
____ ____ Heart attack
____ ____ Heartburn/Indigestion
____ ____ High blood pressure
____ ____ Hospitalizations
____ ____ Surgical procedures
____
____ ____ Kidney disease
____ ____ Liver problems
____ ____ Pacemaker
____ ____ Painful menstruation
____ ____ Palpitation/arrhythmia
____ ____ Peptic ulcer
____ ____ PMS
____ ____ Pregnancy

If pregnant, how many months along ________

Past / Present

____ ____ Sinusitis
____ ____ Stroke
____ ____ Thyroid
____ ____ Medications
____
____
____
____ ____ Other: ____
____

If a family member has had any of the following circle all that apply:

Arthritis Lupus Cancer
Heart Disease Mental
Hypertension

PLEASE READ AND SIGN IF YOU WISH TO BE TREATED WITH ACUPUNCTURE OR ACUPRESSURE.

I, the undersigned, fully understand that no therapeutic treatment, including these, can carry with it any stated or implied guarantee of success. I also understand that these treatments may produce some slight bruising and I release La Verne Acupuncture, A Professional Corporation and Matthew D. Bauer, L.Ac. from responsibility in the event that that should occur.

Patient Signature: ________________________________ Date: ________________