

# Mountain Spirit Acupuncture

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## Patient Information

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone \_\_\_\_\_ Work phone \_\_\_\_\_  
Cell phone \_\_\_\_\_ E-mail \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_  
Gender:  Female  Male Age \_\_\_\_\_ Weight \_\_\_\_\_  
Referred by \_\_\_\_\_ Had acupuncture before?  Yes  No  
Name of primary care physician \_\_\_\_\_  
Notify in emergency \_\_\_\_\_ Phone \_\_\_\_\_

### Main Complaints:

What is your primary reason for seeking treatment? \_\_\_\_\_  
\_\_\_\_\_

When problem began \_\_\_\_\_ Have you had this in the past?  Yes  No

Is your condition:  Getting worse  Staying Constant  Coming & Going

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What diagnosis have you been given? \_\_\_\_\_

What kinds of treatment have you tried? \_\_\_\_\_  
\_\_\_\_\_

Do you have any other complaints or health issues? \_\_\_\_\_  
\_\_\_\_\_

Please list any medications, drugs, herbs or supplements you are taking \_\_\_\_\_  
\_\_\_\_\_

Are you currently under the care of any other health care practitioners?  Yes  No

If so, what treatment and for what conditions? \_\_\_\_\_  
\_\_\_\_\_

Date of last physical exam \_\_\_\_\_ By whom? \_\_\_\_\_

How would you describe your health as a child? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check any illnesses or conditions you have or have had in the past:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Allergies       | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Pace Maker       |
| <input type="checkbox"/> Alcoholism      | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Pneumonia        |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> HIV/AIDS           | <input type="checkbox"/> Mental Disorder  |
| <input type="checkbox"/> Bleeding easily | <input type="checkbox"/> Glaucoma       | <input type="checkbox"/> High fever         | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Jaundice        | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Ulcers         | <input type="checkbox"/> Vascular Disease   | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Hypertension    | <input type="checkbox"/> Weight Loss    | <input type="checkbox"/> Weight Gain        | <input type="checkbox"/> Chronic Fatigue  |
| <input type="checkbox"/> Other _____     |   |   |   |

List any illnesses for which you have been hospitalized (include dates) \_\_\_\_\_

List any surgeries you have had (include dates) \_\_\_\_\_

List any allergies or sensitivities to any medications or other substances \_\_\_\_\_

Is there anything else you'd like us to know about? \_\_\_\_\_

*All of the information given on this form is true and accurate, and I hereby consent to and authorize treatment by the practitioner at Mountain Spirit Acupuncture. I understand that I am responsible for payment of my account, and that payment is due at the time services are rendered.*

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

consent to treat a minor child (name) \_\_\_\_\_

Parent/Legal guardian signature \_\_\_\_\_