(PLEASE PRINT)

Date _____

Patient Information

Home Phone _____

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Sex ☐M ☐F Birthdate _____ Age _____ ☐ Single ☐ Married ☐ Partnered

Address _____ Children? How many? _____

City _____ State _____ Zip _____

Patient Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____

Business Phone _____ Occupation _____

Insurance Company _____

Subscriber/Member Identification # _____ Group # _____

Names of other dependents covered under this plan: _____

Additional Insurance *(for Medicare Patients only)*

Subscriber Name _____

Relation to Patient _____ Birthdate _____

Address (if different from patient's) _____

City _____ State _____ Zip _____

Insurance Company _____

Subscriber/Member Identification # _____ Group# _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Kristina Shaw all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the ... Release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. ↑ Acupuncturist

_____
Responsible Party Signature Relationship Date

Office Use: Reviewed with Patient _____ / _____ / _____ _____

Family History

Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✔) if your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates _____

Serious Illness/Injuries	Outcome	Date

Pregnancies

Year	Sex	Complications if any

Health Habits

Check (✔) which substances you use & describe how much you use:

	Caffeine	
	Tobacco	
	Drugs	
	Alcohol	
	Other	

Occupational

Check (✔) if your work exposes you to the following:

	Stress
	Heavy Lifting
	Hazardous Substances
	Other

Occupation _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ Signature

_____ Date

Office Use: Reviewed with Patient _____ / _____ / _____ _____

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for today's visit? _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year:

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision- Flashes
- ☐ Vision- Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Conditions

Check (✓) conditions you currently have or have had in the past year:

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Medications

List medications you are currently taking:

_____

_____

_____

_____

Allergies

_____

_____

_____

_____

Pharmacy: _____ Phone: _____

Name: _____ **Date** _____

LAST PHYSICAL: DATE_____ DR._____ RESULTS:_____

HABITS: Indicate below: Heavy, Moderate, Light, or None If significant, comment.

Heavy	Moderate	Light	None	
☐	☐	☐	☐	Alcohol:
☐	☐	☐	☐	Coffee:
☐	☐	☐	☐	Tea:
☐	☐	☐	☐	Tobacco:
☐	☐	☐	☐	Exercise:
☐	☐	☐	☐	Sleep:
☐	☐	☐	☐	Appetite:
☐	☐	☐	☐	Energy:
☐	☐	☐	☐	Medication:
☐	☐	☐	☐	Vitamins:
☐	☐	☐	☐	Diet:
☐	☐	☐	☐	Teeth problems:
☐	☐	☐	☐	Drugs:
☐	☐	☐	☐	Salt:
☐	☐	☐	☐	Other:
☐	☐	☐	☐	Stress: _____ (Chemical, physical, psychological)

AVERAGE DAILY DIET

Morning:

Afternoon:

Evening:

Between Meals:

Are you now on (or have you undertaken) a restricted diet? Please describe and indicate when. _____

_____

_____

MEDICINES taken within the last two months (include vitamins, over-the counter drugs, herbs) _____

_____

_____

ALLERGIES: (Drugs, chemicals, foods. Type of reaction.) _____

_____

_____

PM165 (c) C. Flint 1985

(1)

Allergy + Sensitivity Symptoms

If you have one or more of these symptoms, there's a probability you'll benefit from a food sensitivity test.

Please place a checkmark at each of your symptoms and return the completed checklist to your physician. Be sure to include symptoms that you've 'learned to live with'.

Digestive Tract
- ❑ Belching
- ❑ Bloated feeling
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea
- ❑ Passing gas
- ❑ Stomach pains
- ❑ Vomiting

Ears
- ❑ Drainage from ear
- ❑ Ear aches
- ❑ Ear infections
- ❑ Hearing loss
- ❑ Itchy ears
- ❑ Ringing in ears

Emotions
- ❑ Aggressiveness
- ❑ Anxiety/fear
- ❑ Depression
- ❑ Irritability/anger
- ❑ Mood swings
- ❑ Nervousness

Energy & Activity
- ❑ Apathy
- ❑ Fatigue
- ❑ Hyperactivity
- ❑ Lethargy
- ❑ Restlessness
- ❑ Sluggishness

Eyes
- ❑ Blurred vision
- ❑ Dark circles
- ❑ Itchy eyes
- ❑ Sticky eyelids
- ❑ Swollen eyelids
- ❑ Watery eyes

Head
- ❑ Dizziness
- ❑ Faintness
- ❑ Headaches
- ❑ Insomnia
- ❑ Lightheadedness

Joint & Muscles
- ❑ Aches in muscles
- ❑ Arthritis
- ❑ Feeling of weakness
- ❑ Limited movement
- ❑ Pain in joints
- ❑ Stiffness

Lungs
- ❑ Asthma/bronchitis
- ❑ Chest congestion
- ❑ Difficulty breathing
- ❑ Shortness of breath
- ❑ Wheezing

Mind
- ❑ Confusion
- ❑ Learning disabilities
- ❑ Poor concentration
- ❑ Poor memory
- ❑ Stuttering/stammering

Mouth & Throat
- ❑ Canker sores
- ❑ Chronic coughing
- ❑ Gagging
- ❑ Often clear throat
- ❑ Sore throat
- ❑ Swollen tongue/lips/gums

Nose
- ❑ Excessive mucous
- ❑ Hay fever
- ❑ Sinus problems
- ❑ Sneezing attacks
- ❑ Stuffy nose

Skin
- ❑ Acne
- ❑ Dermatitis
- ❑ Eczema
- ❑ Excessive sweating
- ❑ Flushing/hot flashes
- ❑ Hair loss
- ❑ Hives/rashes
- ❑ Itching

Weight
- ❑ Binge eating
- ❑ Compulsive eating
- ❑ Cravings
- ❑ Excessive weight
- ❑ Underweight
- ❑ Water retention

Other
- ❑ Anaphylactic reactions
- ❑ Chest pains
- ❑ Frequent illness
- ❑ Genital itch
- ❑ Irregular heartbeat
- ❑ Rapid heartbeat
- ❑ Urgent urination

Patient's Name:_____ Phone #:_____

Address:_____

Weight:_____ Height:_____

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Symptom Checklist (2) for Allergies + Sensitivities

During the last 30 days, have the symptoms you noted on the previous page...

1. **Prevented you from getting a good night's sleep?** ❑ Yes ❑ No
   If yes, which symptoms?_____ How many nights? _____
2. **Affected your performance at your place of employment?** ❑ Yes ❑ No
   If yes, which symptoms?_____ How many days? _____
3. **Caused you to call in sick to your place of employment?** ❑ Yes ❑ No
   If yes, which symptoms?_____ How many days? _____
4. **Caused you to leave your place of employment early?** ❑ Yes ❑ No
   If yes, which symptoms?_____ How many days? _____

Do you or anyone in your family have a history of allergies? ❑ Yes ❑ No

Have you or has anyone in your family ever been to an allergist or been tested for allergies?

❑ Yes ❑ No

Do you have allergic reactions within 15 minutes or sooner after exposure to particular topical, ingested or inhaled substances such as:

- ❑ Animal danders
- ❑ Cosmetics
- ❑ Dust, pollen or mold
- ❑ Foods
- ❑ Insect stings
- ❑ Iodine
- ❑ Latex
- ❑ Laundry detergent
- ❑ Medicines
- ❑ Penicillin
- ❑ Plants or trees
- ❑ Shampoos or soaps
- ❑ Skin creams
- ❑ Sulfur

If so, can you identify the particular offending substance?

_____

Do you have severe, dramatic allergic reactions (anaphylaxis) with skin reactions, swelling, respiratory distress, and/or low blood pressure?

_____

If so, what causes it? (eg., bee stings, penicillin, etc.)

_____