Full Circle
acupuncture

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Patient Health History Form

Patient Information

Name: _____ Date: _____/_____/_____

Date of Birth: _____/_____/_____ Age: _____ Gender: M/F

Marital status: S M D W Height:_____ Weight:_____

Address:_____ City:_____ Zip:_____

Work Phone:_____ Home Phone:_____

Cell Phone:_____ Email Address:_____

Would you be interested in receiving our free monthly E-newsletter? Y N

Occupation:_____ Employer:_____

How did you here about our clinic?_____

Primary Care Physician:_____ Phone number:_____

Please list all medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

_____

_____

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

_____

_____

_____

Reason For Visit

Please identify the health concerns that have brought you to our clinic in order of importance below:

Condition Past Treatment

a. _____

How does this condition affect you? _____

b. _____

How does this condition affect you?_____

c. _____

How does this condition affect you?_____

d. _____

How does this condition affect you? _____

Do you have any reason to believe you may be pregnant? If so, how far along are you? _____

Do you have any infectious diseases? If yes, please identify: _____

Lifestyle

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

How many glasses of water do you drink per day? _____

Exercise routine: _____

Spiritual practice: _____

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

Hours/Week at work _____ Do you enjoy work? Y N

Why/Why not? _____

Nicotine/Alcohol/Caffeine Use _____

Have you experienced any major traumas? Y N

Explain _____

_____

_____

Personal Medical History

Hospitalizations, Surgeries, X-Rays, CAT Scans, MRIís, Special Studies

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

Emotional (mark 'C' for current and 'P' for past)

___ Mood Swings ___ Nervousness ___ Mental Tension ___ Sudden Anger

___ Depression ___ Nightmares ___ Addictions ___ Obsessive behavior

Energy and Immunity (mark 'C' for current and 'P' for past)

___ Fatigue ___ Slow Wound Healing ___ Chronic Infections

___ Cancer ___ Chronic Fatigue Syndrome

Head, Eye, Ear, Nose, and Throat (mark 'C' for current and 'P' for 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

Respiratory (mark 'C' for current and 'P' for past)

___ Pneumonia ___ Frequent Common Colds ___ Difficulty Breathing ___ Emphysema

___ Persistent Cough ___ Pleurisy ___ Shortness of Breath ___ Asthma

___ Tuberculosis Other Respiratory Problems _____

Cardiovascular (mark 'C' for current and 'P' for past)

___ Heart Disease ___ Chest Pain ___ Swelling of Ankles

___ High Blood Pressure ___ Palpitations/Fluttering ___ Stroke ___ Anemia

___ Heart Murmurs ___ Rheumatic Fever ___ Varicose Veins

Blood Pressure_____/_____ When was this taken?_____ Blood Type _____

Gastrointestinal (mark 'C' for current and 'P' for 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

Genito-Urinary Tract (mark 'C' for current and 'P' for past)

___ Kidney Disease ___ Painful Urination ___ Frequent UTI ___ Frequent Urination

___ Heavy Flow ___ Urinary Dribbling ___ Kidney Stones ___ Impaired Urination

___ Blood in Urine ___ Frequent Urination at Night

Female Reproductive/Breasts (mark 'C' for current and 'P' for past)

___ Irregular Cycles ___ Breast Lumps/Tenderness ___ Heavy Flow ___ Clotting

___ Bleeding Between Cycles ___ Vaginal Discharge ___ Premenstrual Problems

___ Nipple Discharge ___ Menopausal Symptoms ___ Difficulty Conceiving

___ Painful Periods ___ Low Libido

Menstrual/Birthing History

Age of First Menses _____ # of Days of Menses _____ Length of Cycle _____

# of Pregnancies _____ # of Miscarriages _____ # of Abortions _____

# of Live Births _____ Birth Control Type (past and current) _____

Male Reproductive (mark 'C' for current and 'P' for past)

___ Sexual Difficulties ___ Prostrate Problems ___ Testicular Pain/Swelling

___ Penile Discharge ___ Low libido

Musculoskeletal (mark 'C' for current and 'P' for 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?) _____

Neurologic (mark 'C' for current and 'P' for past)

___ Vertigo/Dizziness ___ Paralysis ___ Numbness/Tingling

___ Loss of Balance ___ Seizures/Epilepsy ___ Memory Loss

Endocrine (mark 'C' for current and 'P' for past)

___ Hypothyroid ___ Hypoglycemia ___ Hyperthyroid

___ Diabetes Mellitus ___ Night Sweats ___ Feeling Hot or Cold

Dermatological (mark 'C' for current and 'P' for past)

___ Eczema ___ Hives ___ Shingles ___ Acne

___ Rosacea ___ Psoriasis ___ Warts ___ Rashes

Is there anything else we should know? _____

_____

_____

Acknowledgement of Receipt of Privacy Policy

Your signature below acknowledges that you have received Notice of our Privacy Practices.

Signature:_____ Date:_____

For Motor Vehicle or Workers Comp Patients

Auto/Worker's Comp Insurance

In condition due to accident? Auto Work Accident date: _____

Claim filed? Y N

Claim # _____

Insurance company: _____

Financial Policy

Unless prior arrangement is made, full payment is due at the time of service. Payment may be made by cash, personal check, Visa, or MasterCard. For patients paying **in full** at the time of services, there is a 20% discount on all services. This does not apply to supplements, insurance co-pays or deductibles.

For your convenience, we will bill your insurance provider. We will contact your insurance company for verification of benefits. However, insurance companies may reimburse differently than the information they initially provide to us. You are responsible for and will be billed for any resulting unpaid balance. If we are unable to obtain a verification of benefits from your insurer for any reason, we will require full payment at the date and time of service. You are expected to pay your deductible if it is still due, your co-payment, for any non-covered services, and for all supplements and products at the time of service.

Please provide us with notice of cancellation at least 24 hours in advance of your scheduled appointment. If cancellation notice is less than 24 hours, or you fail to come for a scheduled appointment, there will be a $50.00 fee.

Accounts greater than 30 days past due will be charge a $10 administrative fee. Accounts greater than 90 days overdue will be sent to a collections agency, unless you are making timely payments on an approved payment plan. If you need ongoing medical care, we expect payment on your old balance as well as payment in full for new charges at the time of service. There will be a $35.00 fee for a returned check.

Financial Agreement:

- I have read the policies above and understand them.
- I understand that I will be provided a copy of this policy at my request.
- I agree to promptly pay all fees and charges for treatment provided to me and/or my family.
- I understand that it is my responsibility to contact my insurance company should a claim be denied or not paid in full.
- I understand that I am financially responsible for all charges, whether or not they are covered by my insurance.
- I understand that if I disagree with any charges, I will contact this office in writing within 30 days of the billing date.
- Should legal action be taken by this office to collect an unpaid balance due for services provided, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

These policies are subject to change without notice.

I have read, understood and agree to the policies described above:

Signature:_____ Date:_____