



Acupuncture Patient Information Sheet

Confidential

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Important: Complete this form as thoroughly as possible. All information is confidential

Date: _____ First Name: _____ Middle Initial: _____

Last Name: _____

Gender: M F Date of Birth: / / Age: Height: Weight:

Single Married Life Partner Divorced Widowed

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Email Address: _____ Cell Phone: _____

May we correspond with you (invoices, questions, etc.) via email? Yes No

Would you like to receive a monthly email acupuncture newsletter? Yes No

Occupation: _____ Name of Company: _____

In Case of Emergency Contact: _____

Relationship & Phone: _____

Family Physician: _____ Phone: _____

How did you hear about us? _____

Insurance Information: If Jeffry Batie, LAc will be billing your insurance, please fill out the following:

Name of Primary Insured: _____ Policy/Group Number: _____

Name of Insurance Provider: _____

Address & Phone Number: _____

Insurance Patients I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I authorize the release of any medical information necessary to process this claim and authorize payment of services to this office. I understand any amount paid directly to the office will be credited to my account. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. Please make payment for your portion of charges at each visit unless other arrangements are made.

Patient's Signature _____ Date _____

Patients Without Insurance Please pay for services at the time of each visit. We accept Visa, MasterCard, checks or cash. If you prefer, a payment plan will be set up for your convenience. Let us know which one you prefer (check one).

Payment at time of service Payment plan

Patient's Signature _____ Date _____

(signature of parent or guardian if the patient is a minor)

Patient: _____ Date: _____

Major Complaint(s), in order of importance to you:

1. Severe Moderate Slight _____
2. Severe Moderate Slight _____
3. Severe Moderate Slight _____

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a "C" under appropriate person's column. "P" should be used to indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

	You	Father	Mother	Spouse	Brother(s)	Sister(s)	Children
Age							
Arthritis							
Asthma-Hay Fever							
Back Trouble							
Bursitis							
Cancer							
Constipation							
Diabetes							
Disc Problems							
Emotional Problems							
Emphysema							
Epilepsy							
Headaches							
Heart Trouble							
High Blood Pressure							
Insomnia							
Kidney Trouble							
Liver Trouble							
Migraine							
Nervousness							
Neuritis							
Obesity							
Pinched Nerves							
Scoliosis							
Sinus Trouble							
Stomach Trouble							
Other:							

MEDICAL CONDITIONS – Please list conditions & surgeries you have or have had and year diagnosed.		ALLERGIES Medications, Seasonal, Environmental, Food	OCCUPATIONAL CONCERNS – Check (✓) if your work exposes you to the following.
Year	Condition/Surgery		Occupation:
			<input type="checkbox"/> Stress
			<input type="checkbox"/> Heavy typing/computer use
			<input type="checkbox"/> Hazardous substances
			<input type="checkbox"/> Heavy lifting
			<input type="checkbox"/> Other

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops, nose drops.					
Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

Patient: _____ Date: _____

SYMPTOMS – For each symptom you currently have, rate its severity from 1-5 (5 being the worst). Leave blank if N/A.

LIVER/GALLBLADDER

- Irritability
- Depression
- Headaches/migraines
- Visual problems
- Red eyes
- Dry/itchy eyes
- Spots in front of eyes
- Blurred vision
- Feeling of lump in throat
- Clenching of teeth a night
- Muscle cramping
- Muscle twitching
- Joints feel tight/stiff
- Cold hands/feet
- Soft/brittle nails
- Craving/avoiding sour foods

KIDNEY/URINARY BLADDER

- Urinary problems
- Frequent urination
- Incontinence
- Weakness/pain in lower back
- Aching bones
- Feel cold easily
- Low sexual energy
- Excess sexual desire
- Poor memory
- Loss of hair
- Hearing problems
- Ringing in ears
- Craving/avoiding salty food

HEART/SMALL INTESTINE

- Heart palpitations
- Chest pain
- Dizziness
- Insomnia
- Easily started
- Restlessness/agitation
- Anxiety
- Breathlessness
- Vivid dreams
- Dreams are bothersome
- Lack of joy in life
- Laughing for no reason
- Craving/avoiding bitter foods

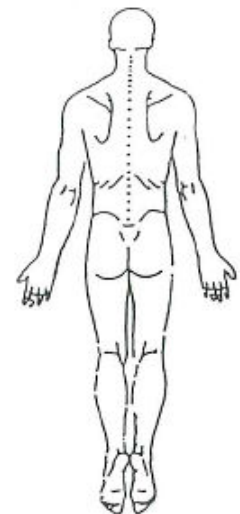
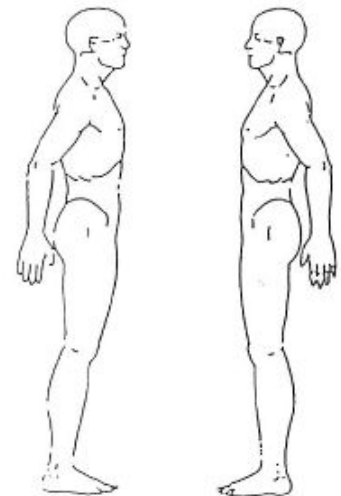
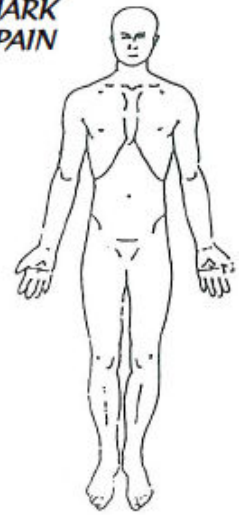
LUNG/LARGE INTESTINE

- Dry cough
- Cough with sputum
- Nasal discharge
- Poor sense of smell
- Nose bleeds
- Itchy, red or painful throat
- Dry mouth
- Skin rashes
- Itchy skin
- Grief, sadness
- Shortness of breath
- Allergies
- Low resistance to colds or flu
- Low physical stamina
- Mild fever comes and goes
- Craving/avoiding spicy foods

SPLEEN/STOMACH

- Heaviness anywhere in body
- Fatigue
- Hard to get up in the morning
- Edema (swelling)
- Muscles feel tired often
- Easy bruising and bleeding
- Bad breath
- Low appetite
- Snacking
- Tendency for hypoglycemia
- Difficulty digesting oily foods
- Nausea
- Vomiting
- Gas/belching
- Bloating
- Hemorrhoids
- Constipation
- Diarrhea
- Abdominal pain
- Indigestion/heartburn
- Over-thinking
- Tendency to become obsessive
- Craving/avoiding sweets

**PLEASE MARK
AREAS of PAIN**



Patient: _____ Date: _____

WOMEN ONLY:

At what age did you get your first period? _____ Date of last menstrual cycle? _____

Are you currently using contraception? Yes No If so, what type? _____

Are you pregnant now? Yes No How many pregnancies have you had? _____ Births? _____

Maternal family history of (please circle): Infertility Fibroids Endometriosis Menstrual Problems
Cancer (type) _____ PMS Menopause

Number of days from the start of one period to the start of the next: _____

Are your menstrual cycles spaced regularly? Yes No

Average number of days of flow: _____ Flow is: Light Normal Heavy

Color is: Pale Normal Dark Bright Red Brown Are clots present? Yes No

Does your period cause you pain or cramping? Yes No If so, when? Before During After

Do you get nausea or vomiting with your period? Yes No If so, when? Before During After

Do you experience any of the following before your period each month? Water Retention Depression

Irritability Breast Tenderness or Swelling Food Cravings Migraines Other _____

Do you ever bleed or spot between periods? Yes No

Do your bowel movements become loose at the beginning of your period? Yes No

Do you have any vaginal discharge between periods? Yes No If so, color: _____

Venereal Disease? Yes No Yeast Infections? Yes No Endometriosis? Yes No

Have you experienced menopause? Yes No If so, when? _____

If you are experiencing menopausal symptoms, please describe: _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such acupuncture care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature _____ Date _____

(signature of parent or guardian if the patient is a minor)

Acupuncturist's Comments: _____

