PATIENT INFORMATION FORM

Filling out forms can be tedious so, to begin with, THANK-YOU for taking the time to do this!

Name: _____ Date: _____
(first) (last) (middle initial)

Age: _____ Date of Birth: _____ Gender: Female / Male

Address: _____ City: _____ Zip Code: _____

Phone Numbers: _____/_____ / _____
(home) (cell) (work)

Email address: _____ Occupation: _____

Marital Status: single committed-unmarried married divorced widow/widower

How did you find out about Kay's acupuncture office? _____

Emergency Contact Person: _____ Relationship: _____

Contact Person's Phone Numbers: _____ /_____/ _____
(home) (cell) (work)

- Are you UNDER 18 years of age? Yes No
- Are you pregnant or suspect that you are pregnant? Yes No
- Are you CURRENTLY undergoing treatment for cancer? Yes No
- Do you have a seizure disorder such as epilepsy? Yes No
- Do you have a blood clotting disorder such as hemophilia? Yes No
- Do you take a blood thinner such as Coumadin/Warfarin? Yes No

If you answered "Yes" to any of the above questions, please stop at this point and ask to speak to the acupuncturist. If you answered "No" to all five questions, please turn to the next page.

What health problem/condition has brought you here for acupuncture? _____
_____

How long has this problem been going on? _____

Have you seen a doctor or other healthcare provider about this situation? What did the doctor or other healthcare provider say or do for you? _____
_____

Are you allergic to any medications? Which one(s)? _____

Are you allergic to anything else? _____

Do you now have – or have you ever had – any of the following diseases or disorders? Put an "X" next to any that apply to you.

Diabetes
Heart attack
Congestive Heart Failure (CHF)
Chronic chest pain
Heart surgery
High blood pressure
Stroke or TIAs
Arthritis
Autoimmune disorder such as scleroderma
Asthma
Lung disease such as emphysema/COPD
Digestive disorders (IBS, ulcerative colitis, diverticulitis)
Kidney disease
Liver disease such as hepatitis or cirrhosis
Gallbladder disease
Anemia
Cancer
Mood disorder such as depression or anxiety
Mental health disorder
Shingles
Neurological disorder such as MS or ALS
Fibromyalgia
ADHD
Major physical trauma such as a concussion, neck or back injury, fractures, etc.

Do you have any other disease or disorder that was not listed? If so, what is it/what are they?
_____

Are you seeing a doctor or other healthcare provider for treatment of any of the above named conditions? _____ Regularly? _____

What – if any – prescription medicines do you take? _____
_____
_____

What – if any – vitamins, supplements, herbs, or over-the-counter remedies do you take?
_____
_____

Do you have a pacemaker or implanted defibrillator? _____

Have you had any joints replaced? Which one(s)? _____
_____

Do you have any metal/titanium rods, plates, pins, screws, or wires anywhere in your body? Where?
_____

Have you had an organ transplant? Which organ? _____

Have you had any surgeries other than the procedures referred to in the past four questions? Please list them. _____
_____
_____
_____