INITIAL HEALTH STATUS
Acupuncture

Patient Name________________________________ Birthdate____________ Sex M / F
Last First MI

Primary Care Physician (PCP)________________ (Required) PCP Phone #____________ (Required)

Are you under the care of a physician? ☐ **No** ☐ **Yes, for what conditions?**______________________
Please describe your current health problem(s)______________________________________
How and When it began______________________________ Is this work related? Y / N
What treatment have you received for the above condition(s)? ☐ Surgery ☐ Medications ☐ Physical Therapy ☐ Injections ☐ Chiropractic ☐ Massage ☐ Other______________________
Please describe your progress: ☐ Worse ☐ No Change ☐ 25% Better ☐ 50% Better ☐ 75% Better or______

Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other______________ ______________
No Pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**
In the past week, how much has your pain interfered with your daily activities?
No Interference 0 1 2 3 4 5 6 7 8 9 10 **Unable to carry on any activities**

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally
Describe your current health condition: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

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Please check all of the following that apply to you and list any medication(s) you are taking:

☐ Alcohol/Drug Dependence
☐ Abnormal Menstruation
☐ Allergies
☐ Angina
☐ Arthritis/ Rheumatoid Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disorder
☐ Breast Lumps
☐ Cancer/Tumor
☐ Convulsions/Seizures
☐ Diabetes
☐ Diarrhea/Constipation
☐ Excessive Thirst
☐ Fainting or Dizziness
☐ Fatigue
☐ Fever
☐ Frequent Urination
☐ Headache
☐ Heart Attack
☐ Heartburn or Indigestion

☐ Hepatitis Type____________
☐ Herpes or other STD - Type____________
☐ High Blood Pressure
☐ HIV/AIDS - Type____________
☐ Hospitalizations/Surgical Procedures____________
☐ Kidney Disease
☐ Liver Problems
☐ Osteoporosis
☐ Pacemaker
☐ Palpitation/Arrhythmia
☐ Peptic Ulcer
☐ Pregnant, # Weeks____________
☐ Prostate Problems
☐ Weight Gain/Loss
☐ Sinusitis
☐ Thyroid Disease
☐ Tobacco Use - Type____________ Frequency____________/Day

☐ Other____________________
☐ **Medications**____________________

If a family member has had any of the following, please mark the appropriate box and explain the relationship:
☐ Cancer____________________
☐ Heart Disease____________________
☐ Hypertension____________________
☐ Lupus____________________
☐ Other____________________

Comments____

I certify that the above information is complete and accurate to the best of my knowledge. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage. I understand that my provider of acupuncture services may need to contact my Primary Care Physician or treating physician if my condition needs to be co-managed. Therefore, I give authorization to my provider of acupuncture services to contact my medical doctor if necessary.

Patient signature__________________________________ **Date**______________