

Initial Health Status



Patient Name _____ Birthdate _____ Sex M / F
Last First MI

Primary Care Physician (PCP) _____ PCP Phone # _____
(Required) (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

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcohol/Drug Dependence | <input type="checkbox"/> Hepatitis Circle: A/B/C | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Abnormal Menstruation | <input type="checkbox"/> Herpes or other STD - Type _____ | _____ |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> Angina | <input type="checkbox"/> HIV/AIDS | _____ |
| <input type="checkbox"/> Arthritis/
Rheumatoid Arthritis | <input type="checkbox"/> Hospitalizations/Surgical Procedures _____ | _____ |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Kidney Disease | If a family member has had any of the following, please mark the appropriate box and explain the relationship:
<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> Hypertension _____
<input type="checkbox"/> Lupus _____
<input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver Problems | |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Breast Lumps | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Palpitation/Arrhythmia | |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Peptic Ulcer | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pregnant, # Weeks _____ | |
| <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Prostate Problems | |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Weight Gain/Loss | |
| <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Sinusitis | |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Thyroid Disease | |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Tobacco Use - Type _____
Frequency _____/Day | |
| <input type="checkbox"/> Frequent Urination | | |
| <input type="checkbox"/> Headache | | |
| <input type="checkbox"/> Heart Attack | | |
| <input type="checkbox"/> Heartburn or Indigestion | | |

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 _____