Acupuncture Solutions
Renew - Relax - Rejuvenate

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Nutrition - Herbal Medicine - Acupuncture
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Patient Profile

Please complete this two-page questionnaire as thoroughly as possible in order to aid Acupuncture Solutions in its diagnosis and treatment.
Note: This is a confidential record of your medical treatment and will not be released, except when you have provided us with written authorization to do so. Thank you.

Patient Information
Please complete this section (print legibly)

Today's Date: _____Last Name: _____First Name: _____ Initial:_____ Age:_____

Other names your records may be kept under: _____

Address: _____

City: _____State & Zip: _____

DOB: _____ Blood Type: _____ Email: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Where would you prefer to be called? (Cell/Work/Home) _____

Guardian's Name* & DOB (minors only): _____

Emergency Contact: _____

Contact's Phone No. _____ Relationship to Emergency Contact: _____

Do You Have Special Needs?_____

Employer/School: _____ Phone No.: _____

Address of Employer/School: _____

How did you hear about us? (Circle one) Newspaper Ad Mailer/Flyer Walk By Facebook

Medical Referral Friend/Family Yellow Pages Insurance Co Other: _____

Medical History
Do you suffer from one or more potentially serious disorder or condition listed below?
Who is your physician? (print legibly)

(__)	Hypertension and/or cardiac conditions	Dr. _____
(__)	Acute, severe abdominal pain	Dr._____
(__)	Undiagnosed neurological changes	Dr._____
(__)	Unexplained weight loss or gain in excess of 15% of your body weight in less than a 3-mo. period	Dr._____
(__)	Suspected fracture or dislocation	Dr. _____
(__)	Suspected systemic infections	Dr._____
(__)	Serious hemorrhagic disorder	Dr._____
(__)	Acute respiratory distress without previous history	Dr._____
(__)	Pregnancy	Dr._____
(__)	Diabetes	Dr._____
(__)	Cancer	Dr._____

Who is your Primary Care Provider? _____
Address: _____ City: _____State: _____ Zip: _____
Telephone: _____

Present Health Concerns
Please complete this section (print legibly)

Please list most important health concerns in their order of significance.	Prior diagnosis of this problem?
1.	
2.	
3.	
4.	
5.	

Have you ever consulted an Acupuncturist before? _____
What is your goal at Acupuncture Solutions? _____
_____
Have you ever been hospitalized; had surgery (when and why) _____
_____
Women: Have you had breast enhancement or breast cancer? When?_____
Are you currently pregnant or nursing? _____

Please list any prescriptive medications that you are currently taking, with dosages:

1._____ 5._____ 9._____
2._____ 6._____ 10._____
3._____ 7._____ 11._____
4._____ 8._____ 12._____

Please list any non-prescriptive medications that you are currently taking, including vitamins, minerals and herbs with dosages:

1._____ 5._____ 9._____
2._____ 6._____ 10._____
3._____ 7._____ 11._____
4._____ 8._____ 12._____

I, the undersigned, pledge that the above information is accurate and complete to the best of my knowledge. I understand that payment is due at the time of service for all visits unless prior arrangements have been made by me. I understand that I am financially responsible for all charges. I understand further that even if my insurance says that they cover Acupuncture benefits, Acupuncture Solutions does not bill insurance. I understand that when I arrive for my initial visit, if I have a potentially serious disorder, Acupuncture Solutions will attempt contact with your doctor. If we are unable to reach your doctor, a letter will be sent them to obtain questions and concerns.

X_____ _____ X_____ _____
PATIENT'S SIGNATURE **DATE** **GUARDIAN'S SIGNATURE** **DATE**

Relationship to Patient:_____
*Guardian's signature required for minor patients