PATIENT INFORMATION FORM

Please Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

First Name M.I. Last Name

Address City State Zip

Home Phone ( ) Mobile ( ) Work ( )

Primary E-mail_____

Date of Birth Age Weight

Occupation Referred By

Physician Physician's Phone

Married ☐ Single ☐ Divorced ☐ Name of Spouse

Emergency Contact Name: Phone: ( )

PRIMARY INSURANCE Co-pay Y/N Co-pay Amount:

Insurance Company ID #

Name of Insured Relationship to Patient: Self Spouse Parent

Secondary Insurance Name of Insured

I understand that this is a quotation of benefits and is NOT a guarantee of payment, and the agreement is between the Insurance Carrier and me. I authorize all payment from my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. Any denial of payment becomes my responsibility (patient).

Patient Name (print) Patient Signature Date

24-HOUR CANCELLATION POLICY
We take pride in the quality of care we offers our patients. In order to do this, it is necessary to enforce a cancellation policy that requires a 24-hour cancellation notice prior to your appointment time. If sufficient time is not given, I understand that the full fee will apply for the broken appointment.

Card Number _____ Exp. Date _____ Security Code ____

Patient Name (print) Patient Signature Date

Name Date

Chief Complaint

I. Major Symptoms: Please list in order of importance what symptoms are of concern to you, and duration of each.

1.

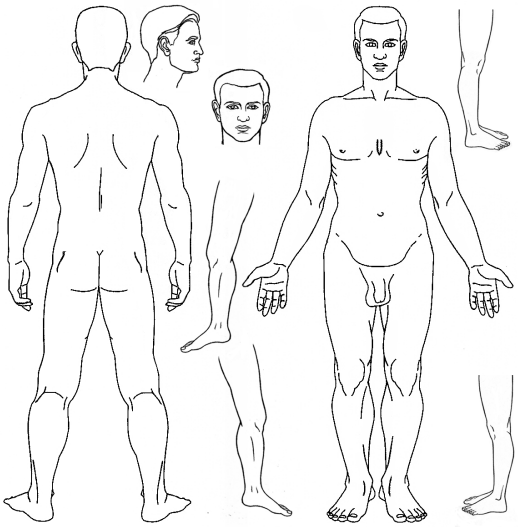
2.

3.

4.

5.

Use the following illustration to indicate painful or distressed areas:



Are you experiencing pain/discomfort in any area of your body? Y/N

If yes, using the models to the left, ptlease indicate the location of the discomfort by using the symbol that best describes the feeling:

XXX Sharp/Stabbing
PPP Pins & Needles
DDD Dull/Aching
NNN Numbness

II. Description: Please list what makes your condition better, what makes it worse, frequency of occurrence, and how your day-to-day activities are affected.

III. Goals: What outcome would you like to achieve through your work with Mountaintop Acupuncture?

IV. Additional information about this condition that was not asked above:

For **Women**:
1. Are you pregnant now? [ ] Yes [ ] No [ ] Unsure

2. Indicate number of occurrences:
Live births _____ Pregnancies _____ Miscarriages _____ Abortions _____

3. Age: First Period _____ Menopause (if applicable _____

4. Date: Last Pap Smear _____/_____ Last Mammogram _____/_____

5. History of an Abnormal Pap Smear [ ] Yes [ ] No If yes, what/when? _____

6. Is Your Menstrual Cycle Regular? [} Yes [ ] No
a) Average number of days of flow _____
b) The flow is [ ] Normal [ ] Heavy [ ] Light
c) The color is [ ] Normal [ ] Dark [ ] Purple [ ] Light Brown [ ] Brown

7. Do you have the following menstruation related signs or symptoms?
[ ] Difficulty with orgasm [ ] Cramps [ ] PMS [ ] Heavy Vaginal discharge between periods
[ ] Pain with Intercourse [ ] Nausea [ ] Bleeding between periods

[ ] Blood Clots [ ] Breast Distension [ ] Vaginal Discharge

For **Men**:
1. Do you have any bothersome urinary symptoms? [ ] Yes [ ] No

Please describe

2. Check all that apply:
[ ] Erectile Dysfunction [ ] Difficulty with orgasm [ ] Pain or Swelling of the Testicles
[ ] Impotence/Erectile Dysfunction [ ] Premature Ejaculation [ ] Feeling of coldness or Numbness in genitalia
[ ] Frequent need to Urinate at Night [ ] Lack of sex drive

3. Do you get up at night to urinate? [ ] Yes [ ] No How Often? _____

4. To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)?

5. Have you sought medical intervention for these problems? If so, when?

6. What treatments have you tried for these problems and how successful have they been?

V. **Medical & Family History**
Please check all that apply and state how you are related to the family member with that condition

Disease Conditions, Age & Date	You	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Heart Disease						
Cancer						
Hypertension						
Stroke						
Asthma						
Allergies						
Migraines/Headaches						
Depression						
Other mental health						
Substance abuse						
Osteoporosis						
Diabetes						
Glaucoma						
Gastroenterological						
Other						

VI. **Medications/Supplements**
Medications you are currently taking)please include prescriptions medicine, supplements, herbal supplements, and over-the-counter medicines you take on a regular basis, along with dosages and brands, if known)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies to medications, chemicals, or foods

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

VII. Nutrition
1. Do you follow a special diet? [ ] Yes [ ] No If yes, how would you describe the diet? (i.e. vegetarian, vegan, low carb, etc.)

2. What do you eat on a “typical” day:
a) Breakfast

b) Lunch

c) Dinner

d) Snacks

e) Foods you tend to crave

f) Foods you dislike

VIII. **Social History**
1. How much per day do you of the following?
Coffee, tea, soft drinks_____ Alcohol_____ Tobacco_____ Other_____
2.Have you ever had a problem with *alcohol* or *alcoholism*? [ ] Yes [ ] No
3. Have you ever had a problem with dependency on other drugs? [ ] Yes [ ] No
4. If yes, which and when?_____
5. Do you have a know history of any exposure to toxic substances? [ ] Yes [ ] No
6. If so, please list which and when you first noticed symptoms?

_____
7. In the past year, how many days have been significantly affected by your health?_____
8 How many days did you feel generally poor? _____
9. How many times were you in the hospital? _____

IX. **Sleep**
1. Do you have trouble (check all that apply) [ ] Falling asleep [ ] Staying asleep [ ] Dream-disturbed Sleep [ ] Waking around ____ am/pm and not being able to fall back to sleep
2. How many hours do you usually get per night during the week? _____
3. Do you wake feeling rested? [ ] Yes [ ] No Do you feel you sleep well at night? [ ] Yes [ ] No

X. **Exercise** [ ] Yes [ ] No
If yes, please describe your current exercise regime:
Hours per week Activities

_____

XI. **Emotions**
1. Who would you describe as your source of primary social support?_____
2. Have you ever been treated suicidal [ ] Treated for emotional problems? [ ]
3. Do you have any neurological or psychological problems? [ ] Yes [ ] No
4. Choose two emotions that dominate your life: 1) _____ 2) _____
5. Are these feelings[ ] Frequently experienced [ ] Difficult to express [ ] Influence other areas of your life
6. Do you have (check all that apply) [ ] Panic attacks [ ] Depression [ ] Anxiety [ ] Nervousness [ ] Fear attacks [ ] Poor memory [ ] Difficulty concentrating [ ] Mood swings [ ] Easily angered
7. Are you in a relationship [ ] Yes [ ] No How do you feel about your relationship? _____
8. How do you deal with stress? _____ How do you relax? _____
9. Please list and briefly describe the most significant events in your life:

_____
_____
_____

XII. **Surgeries**: Please list type of surgeries and date

_____
_____
_____

XIII. **Please provide additional** information you think is relevant for us to know that may not be covered above:

HEALTH HISTORY

GENERAL

Past	Current	Condition
[ ]	[ ]	Poor appetite
[ ]	[ ]	Excessive appetite
[ ]	[ ]	Insomnia
[ ]	[ ]	Fatigue
[ ]	[ ]	Fever
[ ]	[ ]	Night sweats
[ ]	[ ]	Sweat easily
[ ]	[ ]	Chills
[ ]	[ ]	Localized weakness
[ ]	[ ]	Poor coordination
[ ]	[ ]	Bleed or bruise easily
[ ]	[ ]	Catch cold easily
[ ]	[ ]	Change in appetite
[ ]	[ ]	Strong thirst
[ ]	[ ]	Other:_____

SKIN & HAIR

Past	Current	Condition
[ ]	[ ]	Rashes
[ ]	[ ]	Hives
[ ]	[ ]	Itching
[ ]	[ ]	Eczema
[ ]	[ ]	Pimples
[ ]	[ ]	Dryness
[ ]	[ ]	Tumors, lumps

HEAD & NECK

Past	Current	Condition
[ ]	[ ]	Dizziness
[ ]	[ ]	Fainting
[ ]	[ ]	Neck Stiffness
[ ]	[ ]	Enlarged lymph glands
[ ]	[ ]	Headaches
[ ]	[ ]	Concussions
[ ]	[ ]	Other:_____

EAR

Past	Current	Condition
[ ]	[ ]	Infection
[ ]	[ ]	Ringing
[ ]	[ ]	Decreased hearing
[ ]	[ ]	Other:_____

EYES

Past	Current	Condition
[ ]	[ ]	Blurred vision
[ ]	[ ]	Visual changes
[ ]	[ ]	Poor night vision
[ ]	[ ]	Spots
[ ]	[ ]	Cataracts
[ ]	[ ]	Glasses/contacts
[ ]	[ ]	Eye inflammation
[ ]	[ ]	Other:_____

NOSE, THROAT, MOUTH

Past	Current	Condition
[ ]	[ ]	Nose bleeds
[ ]	[ ]	Sinus Infections
[ ]	[ ]	Hay fever or allergies
[ ]	[ ]	Recurring sore throats
[ ]	[ ]	Grinding teeth
[ ]	[ ]	Difficulty swallowing

CARDIOVASCULAR

Past	Current	Condition
[ ]	[ ]	High blood pressure
[ ]	[ ]	Low blood pressure
[ ]	[ ]	Blood clots
[ ]	[ ]	Palpitations
[ ]	[ ]	Phlebitis
[ ]	[ ]	Chest pain
[ ]	[ ]	Irregular heart beat
[ ]	[ ]	Cold hands/feet
[ ]	[ ]	Fainting
[ ]	[ ]	Difficult breathing
[ ]	[ ]	Swelling of hands/feet
[ ]	[ ]	Other:_____

RESPIRATORY

Past	Current	Condition
[ ]	[ ]	Asthma
[ ]	[ ]	Bronchitis
[ ]	[ ]	Frequent Colds
[ ]	[ ]	COPD
[ ]	[ ]	Pulmonary disease
[ ]	[ ]	Pneumonia
[ ]	[ ]	Cough
[ ]	[ ]	Coughing blood
[ ]	[ ]	Production of phlegm
[ ]	[ ]	Other:_____

GASTRO-INTESTINAL

Past	Current	Condition
[ ]	[ ]	Nausea
[ ]	[ ]	Vomiting
[ ]	[ ]	Diarrhea
[ ]	[ ]	Belching
[ ]	[ ]	Blood in stools/black
[ ]	[ ]	Stool soft/dry
[ ]	[ ]	Bad breath
[ ]	[ ]	Rectal pain
[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Constipation
[ ]	[ ]	Pain or cramps
[ ]	[ ]	Indigestion
[ ]	[ ]	Gall bladder disorder
[ ]	[ ]	Gas
[ ]	[ ]	Other:_____

GENITO-URINARY

Past	Current	Condition
[ ]	[ ]	Kidney stones
[ ]	[ ]	Pain or urination
[ ]	[ ]	Frequent urination
[ ]	[ ]	Blood in urine
[ ]	[ ]	Urgency to urinate
[ ]	[ ]	Unable to hold urine
[ ]	[ ]	Other:_____

MALE

Past	Current	Condition
[ ]	[ ]	Pain/Itching genitalia
[ ]	[ ]	Genital lesions/discharge
[ ]	[ ]	Impotence
[ ]	[ ]	Weak urinary stream
[ ]	[ ]	Lumps in testicles
[ ]	[ ]	Other:_____

FEMALE

Past	Current	Condition
[ ]	[ ]	Frequent UTI's
[ ]	[ ]	Frequent vaginal infections
[ ]	[ ]	Pain/itching of genitalia
[ ]	[ ]	Genital lesions/discharge
[ ]	[ ]	Pelvic inflammatory disease
[ ]	[ ]	Abnormal pap smear
[ ]	[ ]	Irregular menstrual periods
[ ]	[ ]	Painful menstrual periods
[ ]	[ ]	Premenstrual syndrome
[ ]	[ ]	Abnormal bleeding
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Breast lumps
[ ]	[ ]	Hot flashes
[ ]	[ ]	Other:_____

NEUROLOGICAL

Past	Current	Condition
[ ]	[ ]	Frequent headaches
[ ]	[ ]	Seizures
[ ]	[ ]	Tremors
[ ]	[ ]	Numbness/tingling of limbs
[ ]	[ ]	Concussion
[ ]	[ ]	Pain
[ ]	[ ]	Paralysis
[ ]	[ ]	Other:_____

PSYCHOLOGICAL

Past	Current	Condition
[ ]	[ ]	Depression
[ ]	[ ]	Anxiety/stress
[ ]	[ ]	Irritability
[ ]	[ ]	Treated for emotional or
[ ]	[ ]	Psychological problems
[ ]	[ ]	Other:_____

INFECTION SCREENING

Past	Current	Condition
[ ]	[ ]	HIV
[ ]	[ ]	TB
[ ]	[ ]	Hepatitis
[ ]	[ ]	Gonorrhea
[ ]	[ ]	Chlamydia
[ ]	[ ]	Syphilis
[ ]	[ ]	Genital warts
[ ]	[ ]	Herpes: oral
[ ]	[ ]	Herpes: genital

MUSCULO-SKELETAL

Past	Current	Condition
[ ]	[ ]	Stiff neck/shoulders
[ ]	[ ]	Low back pain
[ ]	[ ]	Back pain
[ ]	[ ]	Muscle spasm/twitching/cramp
[ ]	[ ]	Sore, cold, or weak knees
[ ]	[ ]	Joint pain