

# INITIAL HEALTH STATUS

Acupuncture and Oriental Medicine

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Primary Language \_\_\_\_\_ Gender M / F  
Last First  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Primary Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Other Phone \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Primary Health Plan \_\_\_\_\_ Patient/Member ID # \_\_\_\_\_  
2nd Health Plan \_\_\_\_\_ 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  0-25% Better  26-50% Better  
 51-75% Better  76-100% Better

**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?  0-25%  26-50%  51-75%  76-100%

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"/> Frequent Urination  | <input type="checkbox"/> Weight Gain/Loss         |
| <input type="checkbox"/> Abnormal Menstruation              | <input type="checkbox"/> Headache  | <input type="checkbox"/> Sinusitis                |
| <input type="checkbox"/> Allergies                          | <input type="checkbox"/> Heart Attack  | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Angina                             | <input type="checkbox"/> Heartburn or Indigestion  | <input type="checkbox"/> Tobacco Use - Type _____ |
| <input type="checkbox"/> Arthritis/<br>Rheumatoid Arthritis | <input type="checkbox"/> High Blood Pressure   | Frequency _____/Day                               |
| <input type="checkbox"/> Artificial Joints                  | <input type="checkbox"/> Hospitalizations/Surgical<br>Procedures _____                                       | <input type="checkbox"/> Thyroid Disease          |
| <input type="checkbox"/> Asthma                             | _____  | <input type="checkbox"/> Other _____              |
| <input type="checkbox"/> Blood Disorder                     | <input type="checkbox"/> Kidney Disease  | <input type="checkbox"/> <b>Medications</b> _____ |
| <input type="checkbox"/> Breast Lumps                       | <input type="checkbox"/> Liver Problems  | _____   |
| <input type="checkbox"/> Cancer/Tumor                       | <input type="checkbox"/> Osteoporosis  |   |
| <input type="checkbox"/> Convulsions/Seizures               | <input type="checkbox"/> Pacemaker   |   |
| <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Palpitation/Arrhythmia  |   |
| <input type="checkbox"/> Diarrhea/Constipation              | <input type="checkbox"/> Peptic Ulcer  |   |
| <input type="checkbox"/> Excessive Thirst                   | <input type="checkbox"/> Pregnant, # Weeks _____   |   |
| <input type="checkbox"/> Fainting or Dizziness              | If pregnant, are you under a<br>medical doctor's care? <input type="checkbox"/> Y <input type="checkbox"/> N |   |
| <input type="checkbox"/> Fatigue                            | <input type="checkbox"/> Prostate Problems   |   |
| <input type="checkbox"/> Fever                              |  |   |

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 practitioner, I understand that I am liable for all charges for services. I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage. I understand that my practitioner 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 practitioner of acupuncture services to contact my medical doctor if necessary.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_