Welcome

The Living Point
Oriental Medicine and Acupuncture

Patient Information

Patient Name
Address:
City: State: Zip
Gender: ☐M ☐F Age: Birth Date:
☐Single ☐Married ☐DP ☐Separated ☐Widowed ☐Divorced
Patient SS#:
E-Mail Address:
Occupation:
Employer:
Employer Address:
Employer Phone:
Spouse's Name:
Spouse's Birth Date: SSN:
Spouse's Occupation:
Spouse's Employer:
Who may we thank for referring you?

Insurance

Who is responsible for this account?
Relationship to Patient:
Insurance Co.
Subscriber #
Is Patient covered by additional insurance? ☐Yes ☐No
Subscriber's Name:
Subscriber Birth Date: SS#:
Subscriber Relationship to Patient
Insurance Co.
Subscriber #

Accident Information

Is condition due to an accident? ☐Yes ☐No
Type of accident: ☐Auto ☐Work ☐Home ☐Other
To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Workers Comp ☐ Other:
Attorney Name (if applicable):
Attorney Phone: Fax:

Phone Numbers

Home:
Work: Ext:
Cell:
Best time and place to reach you:

Emergency Information

IN CASE OF EMERGENCY, CONTACT:
Name:
Relationship: Home Phone:
Work Phone: Ext.:
Cell Phone:

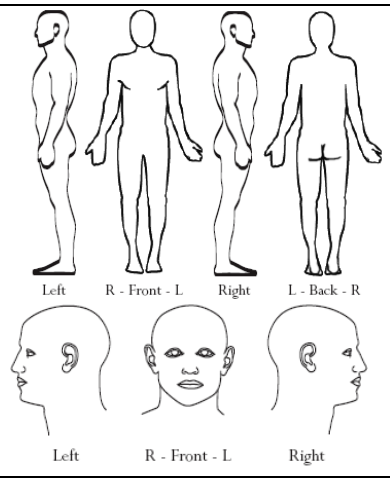
Patient Condition

Your Reason for this Visit:

When did your symptoms appear?

Is this condition getting progressively worse? ☐Yes ☐No ☐Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling:



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain):

Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other:

How often do you have the symptoms? _____ times per ☐ day ☐ week ☐ month ☐ Constantly ☐ Frequently ☐ intermittently ☐ occasionally

Does it interfere with your ☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐Other

Activities or movements that are painful to perform:
☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down ☐Other:

What treatment have you already tried for this condition? ☐None
☐MD / allopathic / Western medicine ☐Surgery ☐Medications ☐Chiropractic
☐Injections ☐ Physical Therapy ☐Naturopathic ☐ Other:

Name and phone of other practitioners who have treated you for your condition:

Date of Last: Physical Exam:	Blood Test:	Urine Test:	Spinal Exam:
Spinal X-Ray:	Chest X-Ray:	Dental X-Ray:	MRI/CT-Scan:

PATIENT NAME:	TODAY'S DATE:

Medical History

Check any of the following conditions you currently have, or have had in the past:

☐ Allergies	☐ Chronic Fatigue Syndrome	☐ High Blood Pressure	☐ Parkinson's disease	☐ Tonsillitis
☐ Anemia	☐ Diabetes	☐ High Cholesterol	☐ Pinched Nerve	☐ Tuberculosis
☐ Aneurysm	☐ Emphysema	☐ Kidney Disease	☐ Pleurisy	☐ Tumors/growths
☐ Appendicitis	☐ Epilepsy	☐ Liver Disease	☐ Pneumonia	☐ Typhoid Fever
☐ Arteriosclerosis	☐ Epstein Barr Virus	☐ Measles	☐ Polio	☐ Ulcers
☐ Arthritis ☐ Rheumatoid ☐ Osteo	☐ Fibromyalgia	☐ Migraine Headaches	☐ Prostate Problem	☐ Vaginal Infections
☐ Asthma	☐ Glaucoma	☐ Miscarriage	☐ Prosthesis	☐ Whooping Cough
☐ Bleeding Disorders	☐ Goiter	☐ Mononucleosis	☐ Rheumatic Fever	☐ Other (specify below)
☐ Breast Lump	☐ Gout	☐ Multiple Sclerosis	☐ Scarlet Fever	☐
☐ Bronchitis	☐ Heart Disease	☐ Mumps	☐ Stroke	☐
☐ Cancer	☐ Hepatitis ☐**B** ☐**C**	☐ Osteoporosis	☐ Seizures	☐
☐ Chicken Pox	☐ Herpes Zoster ("shingles")	☐ Pacemaker	☐ Thyroid disorders	☐

List any Injuries and/or Surgeries you've had	Date
Falls	
Head Injuries	
Broken Bones	
Dislocations	
Surgeries	

Exercise	Work Activity
☐ None	☐ Sitting
☐ Moderate	☐ Standing
☐ Daily	☐ Light Labor
☐ Heavy	☐ Heavy Labor

Habits	
☐ Smoking	Packs/Day:
☐ Alcohol	Drinks/Week:
☐ Coffee/Caffeine drinks	Cups/day:
☐ High Stress	Reason:

Medications	Allergies	Vitamins / Herbs / Minerals

I certify that the information on this 2-page form 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.

Patient Signature: Date:

PATIENT NAME:	TODAY'S DATE:

Restricted Medical History

The following medical history information has additional restrictions placed upon its release to third parties, and will not be disclosed to others unless you explicitly authorize it or we are otherwise ordered by legal authorities to release it:

Please check any of the following conditions you currently have, or have had in the past:

Addictions ☐ **Yes** ☐ **No** If yes, too what substance? If you have stopped using this, when did you stop?
AIDS / HIV ☐ **Yes** ☐ **No** If Yes, Please give date of first diagnosis _____ and date of most recent lab work _____
Alcoholism ☐ **Yes** ☐ **No** If Yes, how long? Are you alcohol-free now? ☐ **No** ☐ **Yes:** since when?
Anorexia ☐ **Yes** ☐ **No**
Bulimia ☐ **Yes** ☐ **No**
Mental Health Disorder ☐ **Yes** ☐ **No** If Yes, please describe:
Suicide Attempt ☐ **Yes** ☐ **No** If Yes, how long ago?
Sexually Transmitted Disease(s) ☐ **Yes** ☐ **No** If yes, please indicate which ones and when they occurred ☐ Chlamydia ☐ Gonorrhea ☐ Genital Herpes ☐ Genital Warts / HPV ☐ NGU ☐ Syphilis ☐ Other
Domestic Violence or Abuse victim ☐ **Yes** ☐ **No**

Acupuncturist's Notes Regarding Information on this Page

Please leave the section below blank for your acupuncturist to fill out; these notes will also be restricted.