Jordan Van Tress MSOM, LAc | 11720 Olio Rd. Ste 400, Fishers, IN 46037
(317)752-4812 | VanTressAcupuncture@gmail.com | VanTressAcupuncture.com

New Patient Information

Name _____ Today's Date _____
Street Address _____ Unit _____

City _____ State _____ Zip _____

Preferred Phone _____ Email _____

Birth Date (include year) _____

Age _____ Gender _____ Height _____ Weight _____
Occupation _____ Employer _____

Marital Status _____ Referred by _____
Emergency Contact: Name _____ Phone _____
Primary Care Physician: Name _____ Phone _____

Other Practitioners Involved In Your Care:
Name _____ Phone _____
Name _____ Phone _____

Fees:

It is our policy that you pay the entire session fee or co-pay at the time of each session. We will provide a minimum of one month's notice of any changes to our fees.
Insurance Company _____

Insurance Company Phone Number (Provider Line) _____
ID # _____

Please bring a photocopy of your insurance card (front and back) **or** bring your card to your first appointment so we can make a copy at the clinic.

Cancellation Policy:

If you need to change or cancel your appointment please notify us within a minimum of 24 hours notice. Failure to do so will result in being charged the equivalent of the cash rate of the missed appointment to your account.

☐ **I understand the cancellation policy.**

Signature:_____ **Date:** _____/_____/_____

Health History:

Have you had acupuncture before? _____ If so, for what reason?_____

_____

Main issue(s) you are seeking treatment for and length of time experiencing each:

_____

_____

_____

Diagnoses from a medical professional and approximate dates of diagnosis (if applicable):

_____

_____

_____

Please list areas of pain or discomfort below with the 1-10 pain scale and a brief history:
(1: barely noticeable pain, 10: excruciating pain)

_____

_____

_____

_____

_____

_____

Please check any symptoms that you have experienced in the past or currently experience:

General

	past	current		past	current
sweating easily during the day	☐	☐	loss of appetite	☐	☐
weight loss/gain	☐	☐	increase in appetite	☐	☐
brain fog or confusion	☐	☐	trouble falling asleep	☐	☐
dizziness/vertigo	☐	☐	trouble staying asleep	☐	☐
fatigue during the day	☐	☐	swollen/sore lymph nodes	☐	☐
fevers	☐	☐	bleed or bruise easily	☐	☐
chills	☐	☐	autoimmune disease	☐	☐

Please elaborate:

_____

Skin & Hair

	past	current		past	current
rashes/hives	☐	☐	psoriasis	☐	☐
eczema	☐	☐	itchy skin	☐	☐
dry skin	☐	☐	acne	☐	☐
oily skin	☐	☐	loss of hair/thinning hair.	☐	☐

Please elaborate:

Head, Ears, Eyes, Nose & Throat

	past	current		past	current
earaches/pressure in the ears	☐	☐	headaches/migraines	☐	☐
ringing in the ears	☐	☐	sinus pressure	☐	☐
hearing loss	☐	☐	nose bleeds	☐	☐
eye floaters	☐	☐	dizziness/vertigo	☐	☐
itchy eyes	☐	☐	teeth/jaw clenching	☐	☐
blurry vision	☐	☐	sore throat	☐	☐
vision loss	☐	☐	swollen throat	☐	☐

Please elaborate:

Cardiovascular/Circulatory

	past	current		past	current
chest pain	☐	☐	swelling/edema	☐	☐
fainting	☐	☐	high blood pressure	☐	☐
lightheadedness	☐	☐	low blood pressure	☐	☐
cold hands & feet	☐	☐	palpitations	☐	☐
heart arrhythmia	☐	☐	heart murmur	☐	☐
shortness of breath	☐	☐			

Please elaborate:

_____

_____

_____

_____

_____

_____

Respiratory

	past	current		past	current
pain on inhaling	☐	☐	sneezing	☐	☐
chest tightness	☐	☐	seasonal/other allergies	☐	☐
cough	☐	☐	phlegm production	☐	☐
asthma	☐	☐	nasal congestion	☐	☐
wheezing	☐	☐	difficulty swallowing	☐	☐
pain behind the eyes	☐	☐			

Please elaborate:

_____

_____

_____

_____

_____

Genito-Urinary

	past	current		past	current
difficulty urinating	☐	☐	urgent/frequent urination.	☐	☐
blood in urine	☐	☐	sores on genitals	☐	☐
pain upon urination	☐	☐	genital pain	☐	☐
STD	☐	☐	yeast infections	☐	☐
bacterial vaginosis	☐	☐			

Please elaborate:

_____

_____

_____

_____

_____

Neurological/Psychological

	past	current		past	current
anxiety	☐	☐	poor memory	☐	☐
depression	☐	☐	quick temper	☐	☐
loss of balance/coordination	☐	☐	easily susceptible to stress	☐	☐
areas of numbness/paralysis	☐	☐	mood swings	☐	☐
irritability	☐	☐	ADD/ADHD	☐	☐
Parkinsons	☐	☐	Multiple Sclerosis	☐	☐

Please elaborate:

_____

_____

_____

_____

_____

Digestive

	past	current		past	current
heartburn	☐	☐	gas	☐	☐
belching	☐	☐	diarrhea	☐	☐
bloating	☐	☐	constipation	☐	☐
nausea	☐	☐	abdominal pain/cramps	☐	☐
vomiting	☐	☐	mucus in stool	☐	☐
chronic bad breath	☐	☐	blood in stool	☐	☐
sores on lips/tongue	☐	☐	hemorrhoids	☐	☐

Please elaborate:

_____

_____

_____

_____

For Women Only:

	past	current		past	current
irregular periods	☐	☐	breast pain	☐	☐
painful periods	☐	☐	vaginal discharge	☐	☐
bleeding between periods	☐	☐	vaginal sores	☐	☐
period clots	☐	☐	hot flashes	☐	☐
menstrual cramping	☐	☐	night sweating	☐	☐

age of first menses _____ duration of typical period _____

duration of typical cycle _____ date of last PAP _____

# of pregnancies _____ # of live births (+ years) _____

# of miscarriages _____ # of abortions _____

Are you currently pregnant or breastfeeding?

_____

Have you been through menopause? Age?

_____

Did you experience a difficult menopause?

_____

_____

_____

_____

Have you ever taken birth control pills? When and for how long? _____

Other premenstrual & menstrual symptoms (bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.)

_____

_____

_____

_____

Please elaborate:

_____

_____

_____

_____

_____

For Men Only:

	past	current		past	current
erectile dysfunction/impotence	☐	☐	ejaculatory pain	☐	☐
varicocele	☐	☐	BPH	☐	☐

Please elaborate:

Lifestyle:

Current medications/herbs/supplements (please list dosages and how long you have been taking each):

Do you follow any certain diet or way of eating? (vegetarian, gluten-free, paleo, etc.)

How much water do you drink per day? Is it filtered and if so, which type of filter do you use?

Have you used antibiotics in the past? If so, when and how often?

Current exercise routine:

Do you or have you ever used tobacco? If so, how often?

Do you or have you ever drank alcohol heavily? If so, how many drinks/week?

Do you or have you ever taken recreational drugs? If so, how often?

Are you currently taking any of the following medications? *(circle if yes and indicate how often)*

Advil/Motrin/Ibuprofen	Aleve/Naproxen	Prednisone/Prednisolone
Celebrex/Celecoxib	Bayer/Aspirin	Acetaminophen/Tylenol

Allergies (medications/foods/chemicals/etc.):

_____

_____

_____

_____

Have you ever had a seizure? If yes, indicate date of last: _____

Please circle any significant illnesses and indicate date:

Cancer	Hepatitis	Diabetes
High blood pressure	Epilepsy	Heart Attack
Stroke	Ulcer Disease	Liver Disease
Colon Polyps	Other _____	

Please list any major surgeries/hospitalizations and approximate dates:

_____

_____

_____

_____

Family Medical History:

☐ Cancer ☐ Seizures ☐ High blood pressure ☐ Stroke ☐ Diabetes

☐ Heart Attack ☐ Hepatitis ☐ Asthma ☐ Other _____

What are your goals for your health?

Please list any other relevant information or issues you would like to discuss:

Thank you for taking the time to fill out these forms. Please let us know if you have any questions or concerns.