FEDERAL WAY ACUPUNCTURE CENTER
PATIENT INFORMATION FORM
This information is confidential

Name: ____ Date: ___________________

Age: ________________ Birth Date: _________________ Sex: M / F

Married: _____ Divorced: _____ Single: ______ Other: _____

Street Address: ____

City: ____ Zip: __________________________

Phone: Home: _________________ Work: _________________ Cell: __________________

Email address: ____

How did you hear about Federal Way Acupuncture Center?

____

Physician: _______________________________ Physician Phone: _____________________

Emergency contact and phone number: ____

Occupation & Employer: ____

Primary Insurer's Name: ____

Birth Date: ____________________ Employer: ____________________________________

Have you ever had acupuncture? Y / N

What is your current concern? ____

____ How Long? ______________________

What other treatments have you tried? ____

____

Medications you are currently taking and for what conditions:

____

____

____

Medical History (Check all that apply)

__ Aids/HIV __ Diabetes __ Emphysema __ Multiple Sclerosis __Polio

__ Allergies __ Cancer __ Diabetes __ Lyme Disease __ Herpes

__ Heart Disease __ Pacemaker __ Seizures __ Hepatitis A/B/C

__ Tuberculosis __ Varicose Veins __ Alcoholism/Substance Abuse

Other: ____

Surgeries: ____

Food intolerances or allergies? ____

How many glasses do you drink of each of the following per day?

Water _________ Soda __________ Coffee __________ Tea __________ Alcohol ___________

Gastrointestinal:

Do you currently have or have you had a major incidence in the past of:

___ Belching ___ Indigestion ___ Ulcers ___ Bloating ___ Acid Reflux

___ Hernia ___ Nausea ___ Vomiting ___ Hemorrhoids

Exercise and Energy:

What kind of exercise do you do? ______________________________ How often? _____________

How is your general energy level? ____

Are you sedentary or active? ____

Emotions and Sleep:

___ Panic Attacks ___ Depression / Anxiety ___ Difficulty Concentrating

___ Nervous / Fearful ___ Poor Memory ___ Sleep Difficulties

Gynecology:

Are you still menstruating? ___________________________

If you have gone through menopause, what age? ___________________

How many days do you bleed? _______________ How long is your cycle? _________________

How many pregnancies/miscarriages? ____

___ Heavy flow ___ Light flow ___ No flow ___ Normal

___ Blood clots ___ PMS ___ Painful periods

___ Uterine fibroids ___ Cystic breasts

Respiratory:

Do you smoke? Y / N ___________ times / day for ____________ years

__Frequent Colds __ Cold Sores __ Asthma __ Cough __ Dry Mouth __ Bleeding Gums

__ Ringing in Ears __ Ear pain __ Sinusitis __ Migraine __ Excessive Phlegm

Cardiovascular:

__Palpitations __Chest pain __Irregular heart beat __Varicose Veins __Cold hands/feet

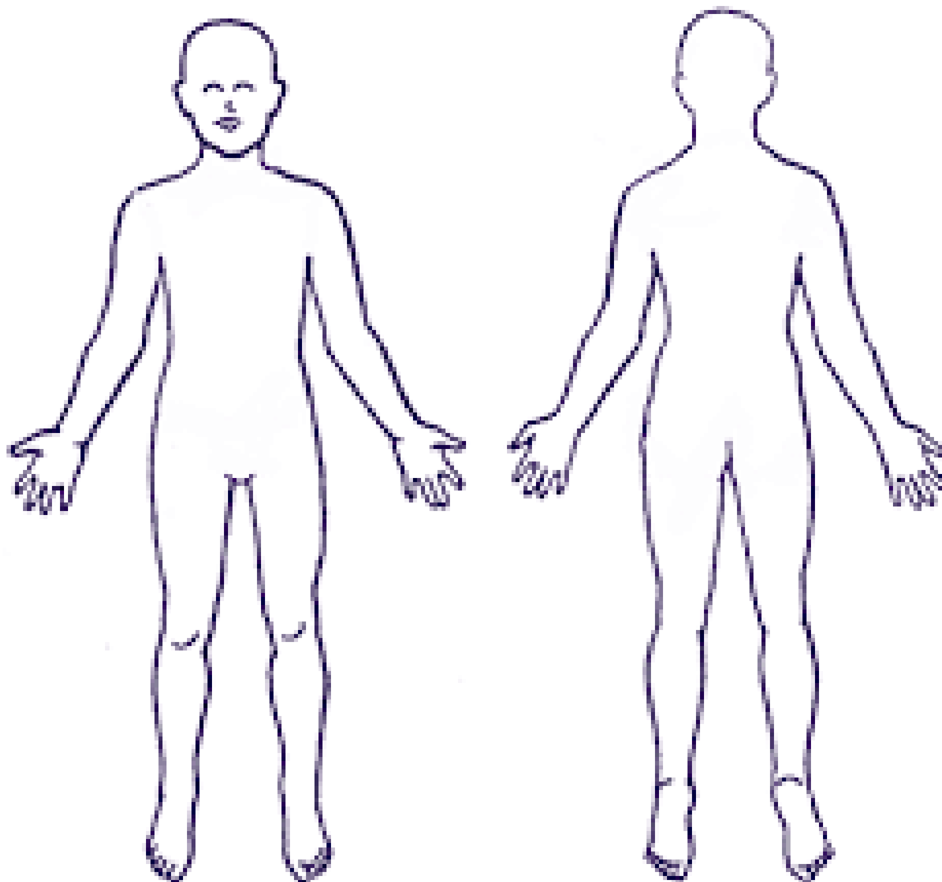
__Poor circulation __Dizziness __High blood pressure __Low blood pressure __ Blood clots

Musculoskeletal:

__ Joint pain __ Arthritis __ Numbness __ Muscle tightness

__ Tendonitis __ Osteoporosis __ Swelling __ Nerve Pain

Mark with an (X) where you are feeling any discomfort or pain.



If pain, please describe: Sharp Dull Stabbing Tight (please circle)

Do you have any additional health conditions or concerns?

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