Family
Health and Wellness

Patient's Name: ______________________________________

Welcome to Our Wellness Clinic! Our Mission: (1) To help as many people as possible with effective natural healthcare; (2) To support long-term well-being; and (3) To empower you with wellness education.

PERSONAL INFORMATION

Full Legal Name:____ DOB ____ / ____ / _______ Age: _____ · M · F

Drivers License#: _________ State: ____ S.S. # ____________________ · Single · Married · Widowed · Divorced
Address: ____________________________________ / ____________________ / ____ / ______ Email: ____________________
(Street Number / PO Box) (City) (State) (Zip Code)
Telephone #'s: ( ) ____________________ / ( ) ______________________ / ( ) ___________________________
(Home) (Work) (Cell or Other)
Employer / School: _____________________________ Address: ______________________Occupation: ____________________
Employer / School Address: ________________________________ / ____________________ / _____________ / ____________
(Street Number / PO Box) (City) (State) (Zip Code)
Spouse (or Partner's) Name: ____________________________________ DOB ___ / ___ / ______ S.S. # ____________________
Emergency Contact: ____________________ Relationship: _______________ Phone: (W) _____________ (H) _______________

How did you hear about our clinic?

- Insurance Provider List · Friend · Family · Magazine · Phone Book · Newspapers · Walk-in
- Website -- Which Search Engine? Google / Yahoo / Other (please explain) ____
- Other _________________________ · If referred, whom can we thank for your visit? ______________________________

Insurance Information—Please provide your insurance card to the front desk

- **Group Health**: Insurance Company: _____________________ Policy #: _______________ Effective Date: _________
- **Motor Vehicle Accident**: Date Occurred: ___ / ___ / ___ Location: ______________ Claim #: ____________________

Insurance Company: _____________________ Claim Submitted: Y / N * Please fill out "**Accidental Injury**" form.
Adjuster's Name: ________________________ Phone: ______________________ Attorney's Name: ________________

- **Worker's Comp or** · **Medicare**: Please fill out additional forms.
- **I have additional healthcare insurance plan(s)** --Plan name & Member # ______________________________________

24-Hour Cancellation or Rescheduling Policy.
Our Clinic observes this standard policy to respond fairly to all our patients' scheduling needs and conduct a more efficient clinical operation. Our clinic will consider waive the $30 fee for the first time for unexpected event and miss appointment. **Initials _____**

Assumption of Financial Responsibility Family Health and Wellness, as a courtesy, will bill my insurance or workers compensation plan, or auto insurance PIP. It is my responsibility to for any balance due that is not covered by my plan(s). I am responsible for 3% monthly finance charge and collection fee if past due. **Initials _____**

Manual Therapy Provider may incorporate manual therapy to maximize therapeutic outcome in addition to acupuncture or other service modality. Manual therapy is to decrease muscles tension/spasm, improve muscles tone, and increase structural range of motion. The benefit is not only to reduce pain, but also to increase functionality and stability. **Initials _____**

I have read this form and my questions are answered to my satisfaction. I hereby consent to treatment.

Insured member signature: **X** ______________________________________ Date: ____ /____ / _______

Responsible Party (*if different from above*): **X** ____________________________ Date: ____ /____ / _______

Patient's Name: ____

MEDICAL INFORMATION

What are your top 3 main complaints?

1. ____ for how long? ___ years ___ months ___ weeks
2. ____ for how long? ___ years ___ months ___ weeks
3. ____ for how long? ___ years ___ months ___ weeks

Height: ___ ft ___ in. Weight: _____lbs. Blood Type: ____ Avg. Blood Pressure: ___________ Pulse Rate: ____ bpm

* **Have you ever had any infectious or communicable diseases? Y/N Please describe: ____________________________**
* **Are you pregnant? Y/N If yes, how long? ____________** * **Do you think you may be pregnant? Y/N**
* Are you allergic to anything? Y/N Please describe: ____
* Do you smoke? Y/N Cigarettes: _____ / day for (how long) ______ years / months * Any history of smoking? Y/N
* Do you drink alcoholic beverages? Y/N Glasses: ___ per day / week * Do you exercise? Y/N Days: _____ /week
* Do you drink caffeinated beverages? Y/N Cups: ___ per day / week * Do you sleep well? Y/N Hours: _____ /night
* Have you ever received psychiatric treatment? Y/N Have you ever considered or attempted suicide? Y/N When? _______
* Do you have good appetite? Y/N * Craving? Y/N If yes, for what? __________ * Do you have seasonal depression? Y/N
* What is your average energy level? (1 ~ 10, 10 = the best) _____ * Did you have acupuncture treatment before? Y/N

Family Medical Physician: Dr. ______________________________M.D./D.O./N.D. **Office** (   ) ______________________

- *When professional health practitioners work together it benefits you.*
  May we have permission to update your doctor regarding your care at this office? Y/N

CURRENT MEDICAL HISTORY

Current Western medicine diagnosed disease(s): (what and when)

____

Medications (prescribed or over-the-counter), herbs, vitamins, supplements, etc., taken within last 3 months:

____

____

Have you ever been diagnosed with any one of the following condition?

☐ Alcoholism ☐ Alzheimer ☐ Asthma ☐ Broken/Fractured Bones
☐ Bleeding disorder ☐ Cancer (_________) ☐ Circulatory Problems
☐ Congenital diseases ☐ Diabetes (type ____) ☐ Drug addiction ☐ Emotional/Mental disorder
☐ Fibromyalgia ☐ Hepatitis (type _ __) ☐ Herpes ☐ Heart disease
☐ HIV /AIDS ☐ Hypertension ☐ Hypoglycemia ☐ Rheumatoid Arthritis
☐ Seizures / Tremors ☐ Stroke ☐ Tuberculosis ☐ Thyroid disease
☐ Ulcers ☐ Venereal disease ☐ Weight problem ☐ Other _____________

Date of Last:

Physical exam _______ X-ray _______ Blood test _______ Urine test _______ Ultra Sound ______
MRI ________CT Scan _______ PAP _______ Mammogram _______ Other ________________

FAMILY HISTORY

	Father	Mother	Brothers	Sisters	Children	Maternal GPs	Paternal GPs
Ages (if living)							
Current Health							
Age at Death							
Cause of Death							

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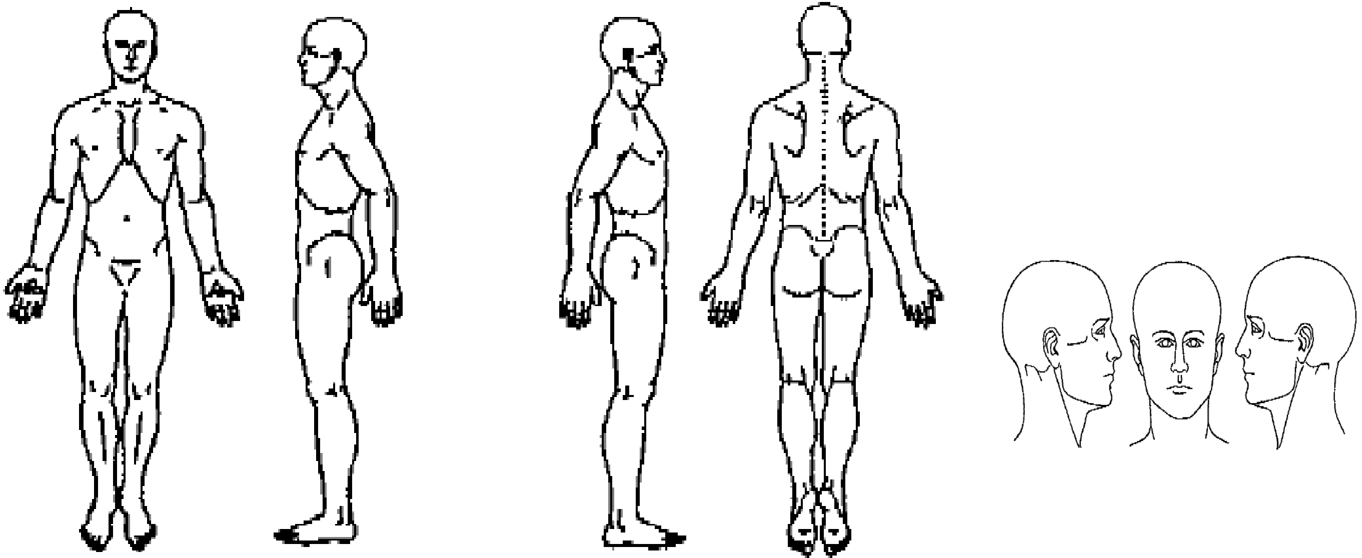
* **Please mark an appropriate** **symbol** **and state the** ***pain level*** (1~10, 10 = the worst)
Numbness "###"   Pins & Needles "----"   Burning "+++"   Achy " XXX "   Stabbing " /// "

For example: for left knee pain with pain level at 2/10: mark "XXX 2" across the L-knee area



What helps to alleviate your pain? ____

What makes your pain worse? ____

PAST MEDICAL HISTORY

Major Illnesses: (what and when) ____
Surgeries: (what and when) ____
____
Injuries / Trauma: (what and when) ____
____

GYNECOLOGY & PREGNANCY (FEMALE ONLY)

# of Pregnancies _____	# of Births _____	# Premature Births _____	# of Abortion _____	# of Miscarriage _____
# of Prolonged Labor _____	# of Forceps _____	# of Caesarean ____		

- **Menstruation:** Please complete this section to the best of your ability even if you no longer menstruate.

Age of 1st Menses: _______   Date of Last Menses: _____   Cycle: ___(days) ____(month)   Duration of Flow: ____ (days)

- Heavy Flow, color _____
- Scanty Flow, color ______
- Painful Period, color ____
- Blood Clots
- Irregular Period ________
- PMS ______________________________
- Vaginal Sores
- Vaginal Discharge (color, quality, frequency, amount) ______________________________
- Yeast Infection
- Menopause (current symptoms) ______________________________ (past symptoms) ______________________

What treatment have you received? ____

- Breast Lumps
- Breast Construction
- Fibroids
- Interstitial Cystitis
- Tubular Ligation
- Hysterectomy
- Lumpectomy
- Mastectomy
- Infertility
- Painful Intercourse
- Osteoporosis
- Other: ________________

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** **Please Check if you have experienced any of the following in the last 3 months** **

Skin & Hair

- Acne
- Change in Hair Texture
- Change in Skin Texture
- Dandruff
- Eczema
- Fungal
- Hair Loss
- Hives
- Itching
- Psoriasis
- Rashes
- Recent Moles
- Ulcers
- Other:________________

ENT + Head & Eyes:

- Blurred Vision
- Cataracts
- Color Blindness
- Dizziness
- Dry Throat
- Earaches
- Eye Pain or Strain
- Facial Pain
- Floaters
- Glaucoma
- Grinding Teeth
- Gum Problems
- Headaches
- Hearing Loss
- Jaw Click
- Migraine
- Mouth Ulcers
- Night Blindness
- Nose Bleeding
- Poor Hearing
- Poor or Double Vision
- Ringing in the Ears
- Recurrent Sore Throat
- Sinus Problem
- Sores on Lips
- Tonsillitis
- Spots in Front of Eyes
- Toothache
- Other:____________________________

Respiratory:

- Asthma
- Bronchitis
- Cough
- Coughing Blood
- Easily Winded
- Emphysema
- Painful Breathing
- Phlegm
- Pneumonia
- Shortness of Breath
- Wheezing
- Other: _________

Cardiovascular:

- Blood Clots
- Chest Pain / Pressure
- Cold Hands or Feet
- Cold Sweats
- Dizziness
- Fainting
- Heart Disease _______________
- High Blood Pressure
- Irregular Heartbeat
- Low Blood Pressure
- Murmurs
- Palpitations
- Phlebitis
- Shortness of Breath
- Swelling of Hand/Feet/Ankle
- Other:_____________

Gastrointestinal:

- Abdominal Pain
- Acid Reflux
- Bad Breath
- Blood in Stools
- Constipation
- Crohn's Disease
- Diarrhea
- Gas or Bloating
- Gastric Ulcers
- Green Stools
- Hemorrhoids
- IBS
- Indigestion
- Jaundice
- Nausea
- Parasites
- Vomiting
- Other: __________
- Bowel Movement: How often? _____________

Genito-Urinary:

- Blood in Urine
- Bed Wetting
- Cloudy Urine
- Discolored Urine
- Frequent Urination
- Genital Sores
- Incontinence
- Kidney Stones
- Low Libido
- Painful Urination
- Profuse Urination
- Scanty Urination
- Urgent Urination
- Urinary Track Infection
- Other: _______________

Neuro-Psychological:

- Anxiety
- Concussion
- Dizziness
- Disorientation
- Easily Angered
- Hearing Voices
- Irritable
- Loss of Balance
- Manic Depression
- Migraines / Headache
- Mood Swings
- Numbness
- Poor Coordination
- Poor Memory
- Seizures
- Other ___________________

Musculo-Skeletal:

- Ankle Pain
- Arthritis
- Back Pain
- Foot Pain
- Hand/Wrist Pain
- Hip Pain
- Headache
- Injuries/Trauma
- Joint Pain
- Knee Pain
- Muscle Cramp/Sore
- Muscle Spasms
- Neck Pain
- Osteoporosis
- Restless Leg
- Shoulder Pain
- Weak Joints
- Weak Muscle
- Other ________________________________

❖ What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to the quality of your health? (Rate from 0 -10, with 10 being 100% committed) ____

❖ If you answered less than 10, what stands between your commitment and 100%? _________________________________