HEALTHY LIVING
ACUPUNCTURE

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This is a **CONFIDENTIAL** questionnaire to help me determine the best treatment plan for you. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition. Thank you.

Personal Information

Name_____ Sex: □ M □ F Age_____ Today's Date _____

Home Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone _____ Work Phone _____

Profession_____ E-mail _____

Birth date_____ If under 18, person responsible for your account_____

Emergency Contact: Name_____ Contact Phone: _____

Whom should we thank for referring you to our office? _____

Have you had acupuncture therapy before? □ Yes □ No With Whom? _____

Marital Status: □ Single □ Married/Partnered □ Divorced □ Widowed

Please indicate if any of the following pertain to you: (marking "yes" does not make you ineligible for treatment, however, it may restrict some of our treatment modalities):
□ Hepatitis □ HIV □ High Blood Pressure □ Seizures □ Pacemaker □ Blood-Thinning Meds □ Pregnancy

□ History of Fainting □ Blood Clotting Disorder □ Bruise Easily □ Cancer/Tumor

Medications/Supplements

Please list any prescription or over-the-counter medications, herbs, vitamins and supplements you are presently taking:

Medications/Herbs/Supplements	**Reason for Taking & How Many Years?**

Please list all <u>MAJOR ILLNESSES/HEALTH CONDITIONS</u> and <u>SURGERIES</u> since birth; *including birth complications.*

AGE **HEALTH CONDITION/SURGERY**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list **all** accidents, falls, fractures, broken bones and other traumas.

AGE **INJURY**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list any other health concerns not mentioned._____

_____

Lifestyle and Exercise and Emotions

Tobacco: □Yes □No # packs_____ per day/week

Coffee: □Yes □No # cups _____ per day/week

Black Tea: □Yes □No # cups _____ per day/week

Soda: □Yes □No # cups _____ per day/week

Recreational Drugs: □Yes □No

Alcohol: □Yes □No # drinks _____ per day/week

Exercise: □Yes □No # days _____ per week

Types of Exercise: _____

Do you have a Prayer/Meditation Practice? □Yes □No

_____

Do you have any known psychiatric or psychological disorders? _____

In general how do you feel emotionally? _____

Is there anything else I should know about you? _____

Family Health History

Please list all major health conditions for the following family members (if known):

Father _____

Paternal Grandfather_____

Paternal Grandmother_____

Mother _____

Maternal Grandfather_____

Maternal Grandmother_____

Siblings_____

While Acupuncture and Oriental Medicine have a great deal to offer as a health care system, it cannot replace the resources available through your Medical Doctor. Please be advised that it is strongly recommended you consult a licensed physician concerning all medical complaints and conditions.

Please list your physician's information:

Doctor/Practice Name: _____
(Physician Name and Title)

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

PHONE: _____

Other Physicians: _____

- In order to receive the best possible health care I authorize the above listed physician(s) and my Acupuncturist, Andrew Appello, to freely converse and share medical records concerning my treatment/diagnosis.
- I have been advised to consult my medical doctor about my condition.
- I have received a copy of this form.
- I have been advised that my personal and health information is confidential, but may be used for insurance billing purposes.
- I agree to turn my cell phone to silent when in the treatment room.
- I understand that I will be billed in full for my session if I cancel or reschedule with less than 24 hour notice.
- Payment is due in full at the time of service.
- I agree to be on time, since appointments are scheduled every 30 minutes. Arriving late could result in loss of appointment.
- In order to avoid scheduling confusion I agree to call - not email - for appointments.
- In order to maintain privacy I will not communicate through text messaging.

_____ X_____ _____
Print Patient Name Andrew Appello, MSOM, L.Ac. RH(AHG),RN Date

X_____ _____
Patient/Legal Guardian Signature Date