



Island Acupuncture

& Massage Therapy

Patient General Information

GENERAL PATIENT INFORMATION

Last Name _____	First Name _____
Home Phone _____	Cell Phone _____
Work Phone _____	Email _____
Address _____	
(street)	(city) (state) (zip)
Date of Birth _____	Occupation _____
Marital Status _____	Age _____
Name of Emergency Contact Person _____	
Phone Number for Emergency Contact Person _____	
Your Primary Care Physician _____	
Are you or your spouse a veteran?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you or your spouse work for the Dare County school system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Who can we thank for referring you? _____	

PATIENT INSURANCE INFORMATION (see attached Insurance Information & Checklist)

Insured's ID Number _____	Insured's Policy Number _____
Insurance Plan Name or Program Name _____	
Patient Relationship to Insured	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
If Relationship is other than "Self," what is Insured's name and DOB? _____	

FOR OFFICE USE ONLY
ICD-9 CODE(S): _____ DATE OF FIRST TREATMENT: _____

Health Concerns

MAIN CONCERN: _____

How does this problem affect your daily activities? _____

When did you first notice symptoms? _____

What kinds of treatment or therapies have you tried? _____

Present Health Concerns

Please list most important health concerns in order of significance

Prior diagnosis of this problem?
If so, what?

1. _____

2. _____

3. _____

4. _____

5. _____

HOSPITALIZATIONS/SURGERIES/ACCIDENTS: _____

ALLERGIES: _____

Current Physical Symptoms

General	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	Weight gain	<input type="checkbox"/>	Night sweats
	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	Weight loss	<input type="checkbox"/>	Fever
	<input type="checkbox"/>	Disturbed sleep	<input type="checkbox"/>	Sweating easily	<input type="checkbox"/>	Chills
	<input type="checkbox"/>	Localized weakness	<input type="checkbox"/>	Bleeding/bruising	<input type="checkbox"/>	Sudden energy drop
	<input type="checkbox"/>	Cravings	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	Poor Balance
	<input type="checkbox"/>	Strong thirst				

Skin & Hair	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Recent moles
	<input type="checkbox"/>	Ulcerations	<input type="checkbox"/>	Pimples	<input type="checkbox"/>	Changes in hair texture
	<input type="checkbox"/>	Hives	<input type="checkbox"/>	Dandruff	<input type="checkbox"/>	Hair loss
	<input type="checkbox"/>	Itching				

Head, Eyes, Ears, Nose, Throat	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Color blindness	<input type="checkbox"/>	Recurrent sore throats
	<input type="checkbox"/>	Concussions	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	Nose bleeds
	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Blurry vision	<input type="checkbox"/>	Grinding teeth
	<input type="checkbox"/>	Glasses	<input type="checkbox"/>	Earaches	<input type="checkbox"/>	Sores on lips or tongue
	<input type="checkbox"/>	Spots in front of eyes	<input type="checkbox"/>	ringing in the ears	<input type="checkbox"/>	Facial pain
	<input type="checkbox"/>	Eye pain	<input type="checkbox"/>	Poor hearing	<input type="checkbox"/>	Teeth problems
	<input type="checkbox"/>	Poor vision	<input type="checkbox"/>	Eye strain	<input type="checkbox"/>	Headaches
	<input type="checkbox"/>	Night blindness	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	Jaw clicks
<input type="checkbox"/>	Photophobia	<input type="checkbox"/>	TMJ	<input type="checkbox"/>	Gum/teeth problems	

Cardio-vascular	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Swelling of feet
	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Blood clots
	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Cold hands or feet	<input type="checkbox"/>	Difficulty in breathing
	<input type="checkbox"/>	Irregular heartbeat	<input type="checkbox"/>	Swelling of hands	<input type="checkbox"/>	Phlebitis
	<input type="checkbox"/>	Tightening in chest	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	Stroke

Respiratory	<input type="checkbox"/>	Cough	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Frequent colds or flu
	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Excessive phlegm

Gastro-intestinal	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Belching	<input type="checkbox"/>	Rectal pain
	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	Black stools	<input type="checkbox"/>	Hemorrhoids
	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Blood in stools	<input type="checkbox"/>	Abdominal pain/cramps
	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	Chronic laxative use
	<input type="checkbox"/>	Gas/bloating	<input type="checkbox"/>	Bad breath	<input type="checkbox"/>	Chron's
	<input type="checkbox"/>	Parasites	<input type="checkbox"/>	Diverticulitis	<input type="checkbox"/>	Colitis

Current Physical Symptoms (cont.)

Genito-urinary	<input type="checkbox"/> Pain on urination	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Sores on genitals
	<input type="checkbox"/> Low to no sex drive	<input type="checkbox"/> Decrease in flow	<input type="checkbox"/> Impotence/frigidity
	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Kidney stones	

Musculo-skeletal	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Back pain	<input type="checkbox"/> Hand/wrist pain
	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Shoulder pain
	<input type="checkbox"/> Knee pain	<input type="checkbox"/> Foot/ankle pain	<input type="checkbox"/> Hip pain
	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Tinnitus	<input type="checkbox"/> Arthritis
	<input type="checkbox"/> Migraines	<input type="checkbox"/> Varicose veins	

Neuro-psychological	<input type="checkbox"/> Seizures	<input type="checkbox"/> Poor memory	<input type="checkbox"/> Anxiety
	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Depression	<input type="checkbox"/> Bad temper
	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Concussion	<input type="checkbox"/> Frequent mood swings

Other Illness	<input type="checkbox"/> HIV positive	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Eating disorder
	<input type="checkbox"/> AIDS	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Jaundice
	<input type="checkbox"/> Epstein-Barr	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis
	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Underweight	<input type="checkbox"/> Overweight

Diet Are you dieting? Yes No

 If yes, are you on a physician prescribed medical diet? Yes No

 Number of meals you eat in an average day: _____

 Describe daily diet: _____

Caffeine Indicate # of cups/cans per day Coffee _____ Tea _____ Cola _____

Tobacco Tobacco _____ packs per day Type? _____ # of years _____

Alcohol Do you drink alcohol? Yes No

 If so, how many drinks per week? _____

Mental Health Is stress a major problem for you? Yes No

 Do you feel depressed? Yes No

 Do you panic when stressed? Yes No

 Do you have problems with eating or your appetite? Yes No

 Do you cry frequently? Yes No

 Have you ever attempted suicide? Yes No

 Have you ever seriously thought about hurting yourself? Yes No

 Do you have trouble sleeping? Yes No

 Have you ever been to a counselor? Yes No

For Women Only

Age at onset of menstruation: _____ Date of last period: _____

Period occurs every _____ days

Number of pregnancies _____ Number of live births _____

Heavy periods, irregularity, spotting, pain or discharge? Yes No

Are you pregnant or breastfeeding? Yes No

Have you had a D&C, hysterectomy or Cesarean? Yes No

Any urinary tract, bladder or kidney infections within the last year? Yes No

Any hot flashes or sweating at night? Yes No

Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around the time of your period? Yes No

Experienced any recent breast tenderness, lumps or nipple discharge? Yes No

For Men Only

Do you usually get up to urinate during the night? Yes No

Do you feel burning discharge from penis? Yes No

Has the force of your urination decreased? Yes No

Have you had any kidney, bladder or prostate infections within the last year? Yes No

Do you have any problems emptying your bladder completely? Yes No

Any difficulty with erection or ejaculation? Yes No

Any testicle pain or swelling? Yes No
