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? ☐ Yes ☐ No

Do you or your spouse work for the Dare County school system? ☐ Yes ☐ 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 ☐ Self ☐ Spouse ☐ 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: ______________________________

____

PLEASE MARK PAINFUL OR DISTRESSED AREAS ON THE CHARTS BELOW

Symbol	Reaction
PAIN	
X	little
XX	moderate
XXX	strong
SWELLING	
^	slight
^^	moderate
^^^	severe
PULSING	
O	slight
OO	moderate
OOO	strong
WEAKNESS/TEMP.	
~	weak
+	hot
SKIN PROBLEMS	
*	skin issue

Exercise

- ☐ Sedentary (No exercise)
- ☐ Mild exercise (e.g. climb stairs, walk 3 blocks, golf)
- ☐ Occasional vigorous exercise (workout/recreation less than 4x/week for 30 min.)
- ☐ Regular vigorous exercise (workout/recreation 4x/week for 30 min.)

Please list drugs, herbs and supplements you currently take:

Current Physical Symptoms

General	☐ Poor appetite	☐ Weight gain	☐ Night sweats
	☐ Insomnia	☐ Weight loss	☐ Fever
	☐ Disturbed sleep	☐ Sweating easily	☐ Chills
	☐ Localized weakness	☐ Bleeding/bruising	☐ Sudden energy drop
	☐ Cravings	☐ Tremors	☐ Poor Balance
	☐ Strong thirst		
Skin & Hair	☐ Rashes	☐ Eczema	☐ Recent moles
	☐ Ulcerations	☐ Pimples	☐ Changes in hair texture
	☐ Hives	☐ Dandruff	☐ Hair loss
	☐ Itching		
Head, Eyes, Ears, Nose, Throat	☐ Dizziness	☐ Color blindness	☐ Recurrent sore throats
	☐ Concussions	☐ Cataracts	☐ Nose bleeds
	☐ Migraines	☐ Blurry vision	☐ Grinding teeth
	☐ Glasses	☐ Earaches	☐ Sores on lips or tongue
	☐ Spots in front of eyes	☐ Ringing in the ears	☐ Facial pain
	☐ Eye pain	☐ Poor hearing	☐ Teeth problems
	☐ Poor vision	☐ Eye strain	☐ Headaches
	☐ Night blindness	☐ Sinus problems	☐ Jaw clicks
	☐ Photophobia	☐ TMJ	☐ Gum/teeth problems
Cardio-vascular	☐ Dizziness	☐ High blood pressure	☐ Swelling of feet
	☐ Low blood pressure	☐ Fainting	☐ Blood clots
	☐ Chest pain	☐ Cold hands or feet	☐ Difficulty in breathing
	☐ Irregular heartbeat	☐ Swelling of hands	☐ Phlebitis
	☐ Tightening in chest	☐ Palpitations	☐ Stroke
Respiratory	☐ Cough	☐ Bronchitis	☐ Frequent colds or flu
	☐ Asthma	☐ Shortness of breath	☐ Excessive phlegm
Gastro-intestinal	☐ Nausea	☐ Belching	☐ Rectal pain
	☐ Vomiting	☐ Black stools	☐ Hemorrhoids
	☐ Diarrhea	☐ Blood in stools	☐ Abdominal pain/cramps
	☐ Constipation	☐ Indigestion	☐ Chronic laxative use
	☐ Gas/bloating	☐ Bad breath	☐ Chron's
	☐ Parasites	☐ Diverticulitis	☐ Colitis

Current Physical Symptoms (cont.)

Genito-urinary	☐ Pain on urination	☐ Incontinence	☐ Sores on genitals
	☐ Low to no sex drive	☐ Decrease in flow	☐ Impotence/frigidity
	☐ Blood in urine	☐ Kidney stones	
Musculo-skeletal	☐ Neck pain	☐ Back pain	☐ Hand/wrist pain
	☐ Muscle pain	☐ Muscle weakness	☐ Shoulder pain
	☐ Knee pain	☐ Foot/ankle pain	☐ Hip pain
	☐ Sciatica	☐ Tinnitus	☐ Arthritis
	☐ Migraines	☐ Varicose veins	
Neuro-psycholog-ical	☐ Seizures	☐ Poor memory	☐ Anxiety
	☐ Dizziness	☐ Depression	☐ Bad temper
	☐ Loss of balance	☐ Concussion	☐ Frequent mood swings
Other Illness	☐ HIV positive	☐ Rheumatic fever	☐ Eating disorder
	☐ AIDS	☐ Hypoglycemia	☐ Jaundice
	☐ Epstein-Barr	☐ Diabetes	☐ Hepatitis
	☐ Mononucleosis	☐ Underweight	☐ 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 ___________

Question	Yes	No
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

Question	Yes	No
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