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? _____

FOR OFFICE USE ONLY
ICD-10 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: _____

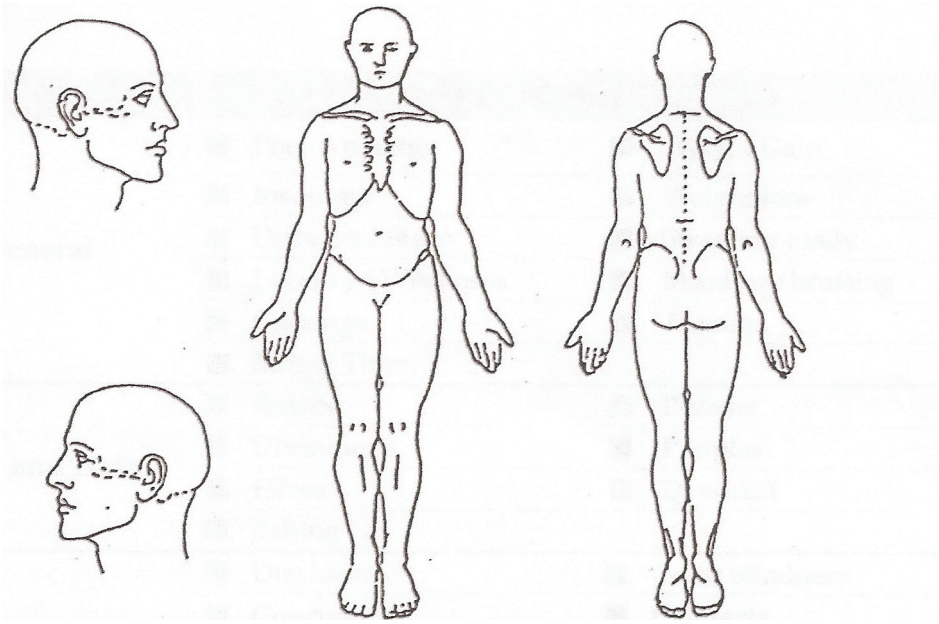
_____

_____

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:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____