

Acumen Health Clinics

Patient registration and symptoms.

We welcome you to our office and are very happy that you are taking the time to take care of yourself. We request that you complete these simple forms and answer the health related questions so we may help you as quickly as we can.

First Name: _____ Last Name: _____

Date of birth: _____ Please circle: Single, Married, Widowed, Divorced, Separated

Home address: _____

Phone: _____ Cell: _____ Email: _____

SS#: _____ Drivers License#: _____ Responsible party: _____

Occupation: _____ Employer: _____

Employer's address: _____

Phone #: _____ (Is it OK to call you there?): Yes No

Name and phone # for a relative or friend we may contact in case of emergency? _____

_____ Who referred you to our office? _____

Do you have medical or health insurance? Yes / No With which company?: _____

Is this covered by: WC? Med pay? Health Insurance? Patient is responsible?

Please give the front office your insurance card so they can verify your coverage. Thank you

What is the reason for today's visit? _____

Have you had this condition before? _____

Who else have you seen for this condition? _____

What makes it better? _____ Worse? _____

Are you taking medication? If yes please tell us what: _____

How is your sleep? _____ Do you fall asleep easy? _____

How many hours do you sleep? _____ Are you refreshed when you wake up? _____

How is your appetite? _____ What do you eat for breakfast? _____

Lunch? _____ Dinner? _____

What is your favorite food? _____ What do you like least? _____

Any Digestion complaints? Belching? Fullness? Heartburn? _____

Do you have a BM daily? _____ How many times? _____ If not daily, how frequently: _____

How many times do you urinate? _____ Have to get up at night? _____

Do you feel more cold compared to others? _____ Warmer? _____ Thirsty? _____

Do you have any pain now? _____ Where? _____

Are you under unusual stress? _____ Why? _____

Do you get cold easily? _____ When was the last one? _____

Any problems breathing? Allergies? Shortness of breath? _____

How is your skin? Dry? Oily? Delicate? Itchy? _____

Ok we are nearly finished.....

Any chest pain? High or low blood pressure? _____

Irregular heart beat? _____ Heart beating too fast? _____

Please tell me about your period. Is it regular? _____ How many days _____

Do you have pain? _____ What makes it better? _____

Do you feel tired before the period? _____ During ? _____ After? _____

Do you feel moody before the period? _____ Do you have blood clots? _____

Have you been pregnant? _____ Children? _____ How many & ages _____

Do you have any eye problems? _____ Glasses / Contact ? _____

Hearing OK ? _____ Ringing in the ears? _____ Pain? _____

Nasal Problems? _____ Snoring ? _____ Allergies? _____

HOORAY !!!! You completed the questioners! Is there anything else you want to tell us? Please use the space below to let me know.

A note from JO at the front office;

I am happy to prepare for you the forms to send to your insurance company and will do so to help you. However, if your insurance company has not verified that they will pay for your treatment while you are receiving care at the office, we would like you to pay us today. We accept Credit Cards, Checks, Cash and pink slips. We will give you a Super bill and you will be reimbursed directly by your insurance company. Currently **Medicare** does not cover acupuncture.

Name: _____ Signature _____ Date _____

Your first treatment may last between an hour and 15 minutes to an hour and 45 minutes, of which you will relax in a room with needles for about 45-60 minutes. The following visit will take between an hour and an hour and 15 minutes.