Acumen Health Clinics

Patient Tegistration and Uymptoms

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 this simple form and answer the health related questions so we may help you as quickly as we can.

First Name: ___________________________ Last Name: ____________________________________

Date of birth: __________ Please check: 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 a 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 us 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 questionaire! Is there anything else you want to tell us? Please use the space below to let me know.

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<u>A note from JO at the front office:</u>

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.