Marion Chiropractic Clinic

1036 Mt. Vernon Ave, Marion, Ohio 43302 ◆ 3967 Presidential Pkwy., Suite B Powell Ohio 43065

ACUPUNCTURE PATIENT INFORMATION

Name_____

Address_____

City_____

State_____ Zip_____

SS# _____ Sex: ☐ Male ☐ Female

Date of birth_____ Age_____

Marital status: Single Married Divorced Separated Widow

Occupation_____

Employer _____

Spouse's Name_____

Spouse's Employer_____

Do you have kids? ☐ Yes ☐ No: # of children _____

Name of family doctor _____

May we contact them regarding your health? ☐ Yes ☐ No

How did you hear about this office?_____

_____

FINANCIAL POLICY

NOTICE TO OUR NEW PATIENTS:

It is the policy of this office for patients to make payment (cash payments, co-payments, etc.) for services rendered **prior to each visit**. Other payment arrangements (ie. payment plans, etc) must be specifically discussed and/or approved by this office prior to treatment initiation. Deductible payments will be billed on receipt of insurance EOB. See financial policy for further details.

Initials: _____

NOTES / COMMENTS

Most insurance companies do not have coverage for acupuncture. Please let us know if your insurance carrier has coverage for acupuncture prior to your treatment. In any case, you will be financially responsible for your acupuncture treatments according to our financial policy.

PHONE NUMBERS, E-MAIL, & EMERGENCY CONTACT

Home #:_____ Cell:_____ Other:_____

May we leave a message / voicemail at the above contact numbers? ☐ Yes ☐ No

E-Mail Address: _____ May we contact you by e-mail? _____

Would you be interested in receiving an e-mail health newsletter? ☐ Yes ☐ No If yes, please initial: _____

Emergency Contact Information

Name_____ Relationship_____ Best contact phone #:_____

Additional information:

Important Questions:

Have you ever had acupuncture? ☐Yes ☐No If yes, when was the last treatment: _____

Have you ever had acupuncture for this condition? ☐Yes ☐No If yes, when was the last treatment: _____

Have you ever had a bad reaction to acupuncture? ☐Yes ☐No Explain: _____

Do you have any bleeding disorders? ☐Yes ☐No Explain: _____

Are you on any blood thinners (Coumadin)? ☐Yes ☐No What medicine: _____

Do you currently or have you ever had an infectious disease? ☐Yes ☐No If yes, explain:

Are you currently pregnant? ☐Yes ☐No

Are you presently trying to get pregnant? ☐Yes ☐No

_____ _____ **Reviewed by: _____**

Signature of Patient/Parent/Guardian/POA **Date**

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PATIENT NAME:

CURRENT COMPLAINT(S) / CONDITION(S)

What conditions do you want treated with acupuncture? Reasons for your visit:

1. _____
2. _____
3. _____

How and when did your problem start?_____

Rate your discomfort level *today*, on a scale from **0 (no pain)** to **10 (the worst imaginable)**: _____

Is your condition? ☐ Constant **(100% of day)** ☐ Frequent **(75% of day)** ☐ Occasional **(50% of day)** ☐ Intermittent **(25% of day)**

Describe the condition:

Is your condition? ☐ Getting better ☐ Staying the same ☐ Getting worse ☐ Unknown

Does it interfere with? ☐Work ☐Sleep ☐Recreation ☐Daily Activity ☐Nothing ☐Other _____

What other activities does it interfere with?

What tests have you had? ☐X-rays ☐MRI ☐EMG ☐Ultrasound ☐Lab work ☐ Other: _____

What treatment have you had? ☐ MD ☐PT ☐Medication ☐Injections ☐Surgery ☐Other _____

Has the treatment helped? ☐Yes ☐No **If yes, explain:** _____

How is your energy? ☐ High ☐ Low **Do you fatigue easily?** ☐ Yes ☐ No

Do you have: ☐ Depression ☐ Anxiety ☐ Nervousness ☐ Panic attacks ☐ Bad temper ☐ Poor memory ☐ Poor concentration ☐ Other Stress ☐ Explain:

Do you have difficulty with: ☐ Falling asleep ☐ Staying asleep ☐ nightmares ☐ Waking up at _____

DATES OF MOST RECENT EXAMS

Spinal X-ray _____ Physical exam _____ Chest X-ray _____ Blood work _____ Other _____

LIST ALL PREVIOUS INJURIES, HOSPITALIZATIONS, AND/OR SURGERIES

Injuries/Falls: _____

_____

Surgeries: _____

_____

Fractures: _____

_____

Other hospitalizations or information:

_____

FOR FEMALES ONLY

Do you use birth control: ☐Yes ☐No	Are you pregnant: ☐Yes ☐No	Due Date:	Date of last period:

** By selecting no, I hereby notify all concerned that I neither suspect nor know positively at this time that I may be or am pregnant. Initials _____

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PATIENT NAME:

SOCIAL HISTORY

Exercise Activity	**Use of Alcohol**	**Use of Tobacco**	**Work Activity**	**Sleep Habits**
☐ None	☐ Never	☐ Never	☐ Sitting	☐ 0-2 hrs/night
☐ Light	☐ Rarely	☐ Previously, but quit	☐ Standing	☐ 2-4 hrs/night
☐ Moderate	☐ Moderate	☐ Currently	☐ Light labor	☐ 4-6 hrs/night
☐ Strenuous	☐ Daily	_____ Packs per day	☐ Heavy labor	☐ 6-8 hrs/night
	_____ drinks per week	_____ # of years	☐ Other	☐ more than 8 hrs/night

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS please check ☑ any that apply to you

Constitutional
- ☐ Bad general health
- ☐ Recent weight change
- ☐ Fever
- ☐ Fatigue
- ☐ Headaches

Eyes
- ☐ Eye disease/injury
- ☐ Glasses or contact lens
- ☐ Blurred / double vision

Ear, Nose, Throat
- ☐ Hard of Hearing
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Sore throat / voice change
- ☐ Swollen glands

Neurological
- ☐ Seizures or Epilepsy
- ☐ Numbness / Tingling
- ☐ Tremors
- ☐ Stroke
- ☐ Multiple Sclerosis

Musculoskeletal
- ☐ Joint Pain / Stiffness
- ☐ Joint Swelling
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Chronic fatigue
- ☐ Fibromyalgia

Cardiovascular
- ☐ Chest pain / Palpitations
- ☐ Dizziness / Fainting
- ☐ Shortness of breath
- ☐ Swelling in hands / feet
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Congestive heart failure

Gastrointestinal
- ☐ Heartburn / Belching
- ☐ Nausea/Vomiting
- ☐ Diarrhea/Constipation
- ☐ Blood in stools
- ☐ Gall bladder problems
- ☐ Liver problems
- ☐ Ulcers

Genito-urinary
- ☐ Pain / Difficulty urinating
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Kidney problems

Respiratory
- ☐ Cough / excessive mucus
- ☐ Congestion / colds / flu
- ☐ Wheezing
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia

Psychiatric
- ☐ Anxiety / Depression
- ☐ Mood Swings
- ☐ Difficulty sleeping
- ☐ Memory loss

Hematologic/Lymphatic
- ☐ Slow to heal after cuts
- ☐ Bleed or bruise easily
- ☐ Anemia
- ☐ Enlarged glands

Endocrine
- ☐ Excessive thirst / urination
- ☐ Heat or cold intolerance
- ☐ Skin becoming drier
- ☐ Diabetes (Type I / Type II)
- ☐ Thyroid disorder

Integumentary (skin, breast)
- ☐ Rash / Sores / Hives
- ☐ Lesions
- ☐ Breast pain or lump
- ☐ Dermatitis/Eczema/dry skin

Allergic/Immunologic
- ☐ Food allergies
- ☐ Airborne allergies
- ☐ Systemic Lupus
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Other (see below)

Other:
Alcoholism
Infertility
Menstrual disorders
Insomnia
Anxiety / depression

FAMILY HISTORY

	Living		Rheumatoid Arthritis		Cancer		Diabetes		Heart, Lung, or Hypertension		Neck, Back, or Disc problems	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brothers/Sisters	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

MEDICATIONS / TAKEN FOR:	*SUPPLEMENTS/VITAMINS/HERBS*	*ALLERGIES (Meds, seasonal, etc.)*
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

WHAT IS YOUR GOAL IN OUR OFFICE?

_____ _____ **Reviewed by:** _____

Signature of Patient/ Parent of Minor/Guardian **Date**

**To the best of my knowledge, the questions on these forms have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Marion Chiropractic Clinic of any changes in my personal information, insurance changes, or medical status in a timely manner. Initials: _____