Marion Chiropractic Clinic

1069 Delaware Ave. Suite 201, Marion, Ohio 43302

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:

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 have a pacemaker? ☐Yes ☐No If yes, when implanted: ______________________________

Have you ever been diagnosed with congestive heart failure (CHF)? ☐Yes ☐No

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 ________________

What are your goals of treatment? Check all that apply:

☐ **I just want relief from my immediate symptoms / pain** ☐ **I want to correct the causes to prevent future problems**

☐ **Other goals (Explain):**

DATES OF MOST RECENT EXAMS

Spiral 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.

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

______________ **Date**

Reviewed by: ______________________

**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: __________