

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

Signature of Patient/Parent/Guardian/POA _____

Date _____

Reviewed by: _____

Marion Chiropractic Clinic

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

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

Marion Chiropractic Clinic

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

PATIENT NAME: _____

SOCIAL HISTORY

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

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

Constitutional <input type="checkbox"/> Bad general health <input type="checkbox"/> Recent weight change <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Headaches Eyes <input type="checkbox"/> Eye disease/injury <input type="checkbox"/> Glasses or contact lens <input type="checkbox"/> Blurred / double vision Ear, Nose, Throat <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Vertigo <input type="checkbox"/> Sinus problems <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sore throat / voice change <input type="checkbox"/> Swollen glands Neurological <input type="checkbox"/> Seizures or Epilepsy <input type="checkbox"/> Numbness / Tingling <input type="checkbox"/> Tremors <input type="checkbox"/> Stroke <input type="checkbox"/> Multiple Sclerosis	Musculoskeletal <input type="checkbox"/> Joint Pain / Stiffness <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Fibromyalgia Cardiovascular <input type="checkbox"/> Chest pain / Palpitations <input type="checkbox"/> Dizziness / Fainting <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Swelling in hands / feet <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart attack <input type="checkbox"/> Congestive heart failure Gastrointestinal <input type="checkbox"/> Heartburn / Belching <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Diarrhea/Constipation <input type="checkbox"/> Blood in stools <input type="checkbox"/> Gall bladder problems <input type="checkbox"/> Liver problems <input type="checkbox"/> Ulcers	Genito-urinary <input type="checkbox"/> Pain / Difficulty urinating <input type="checkbox"/> Blood in urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Kidney stones <input type="checkbox"/> Kidney problems Respiratory <input type="checkbox"/> Cough / excessive mucus <input type="checkbox"/> Congestion / colds / flu <input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Pneumonia Psychiatric <input type="checkbox"/> Anxiety / Depression <input type="checkbox"/> Mood Swings <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Memory loss Hematologic/Lymphatic <input type="checkbox"/> Slow to heal after cuts <input type="checkbox"/> Bleed or bruise easily <input type="checkbox"/> Anemia <input type="checkbox"/> Enlarged glands	Endocrine <input type="checkbox"/> Excessive thirst / urination <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Skin becoming drier <input type="checkbox"/> Diabetes (Type I / Type II) <input type="checkbox"/> Thyroid disorder Integumentary (skin, breast) <input type="checkbox"/> Rash / Sores / Hives <input type="checkbox"/> Lesions <input type="checkbox"/> Breast pain or lump <input type="checkbox"/> Dermatitis/Eczema/dry skin Allergic/Immunologic <input type="checkbox"/> Food allergies <input type="checkbox"/> Airborne allergies <input type="checkbox"/> Systemic Lupus <input type="checkbox"/> Cancer <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brothers/Sisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICATIONS / TAKEN FOR: SUPPLEMENTS/VITAMINS/HERBS ALLERGIES (Meds, seasonal, etc.)

1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.
----------------------------	----------------------------	----------------------------

WHAT IS YOUR GOAL IN OUR OFFICE? _____

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: _____