

Total Acupuncture, LLC. Patient Intake

Please Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

First Name:	Middle Initial:	Last Name:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email:	
Birth Date:	Age:	Social Security #:	
Gender: Male Female	Marital Status: Single Married		
Emergency Contact:	Relationship:	Phone Number:	
Employer:	Occupation:		
Chief Complaint:			

List past illnesses, surgeries and hospitalizations:

Please indicate with a check mark (✓) if any of the following pertain to you:

Anemia	Cancer	Chlamydia	Diabetes	Gonorrhea
Heart Disease	Hemophilia	Hepatitis	Herpes	HIV/AIDS
HPV	Hypertension	Seizures	Syphilis	Tuberculosis

24 HOUR CANCELLATION POLICY

In fairness to both new and returning patients our office maintains a 24 hour cancellation policy. When booking appointment visits, patients agree to pay the entire fee for visit if they fail to provide 24 hour prior notice of cancellation.

Patient Name (Print): _____ Date: _____

Patient Signature: _____

(Or Patient Representative – Indicate relationship if signing for patient)

For Women

Are you pregnant? Yes _____ No _____

of pregnancies _____ # of live births _____ # of abortions _____ # of miscarriages _____

Age of first period (menarche) _____ Age of last period (menopause) _____ # of days between periods _____ #

of days of flow _____ Color of flow _____ Clots? Yes _____ No _____ Color _____

Average # of pads you use per day: 1st day _____ 2nd day _____ 3rd day _____ 4th day _____ + days _____

Have you been diagnosed with: Uterine Fibroids _____ Fibrocystic Breasts _____ Endometriosis _____

Ovarian cysts _____ Pelvic Inflammatory Disease _____ Other _____

Location of pain: Lower abdomen _____ Lower back _____ Thighs _____ Other _____

Nature of pain (if applicable indicate **Before**, **During** or **After** menses):

Cramping _____ Stabbing _____ Burning _____ Aching _____ Dull _____

Bloating _____ Consistent _____ Intermittent _____ Bearing down sensation _____

Other symptoms related to menses (please check next to applicable symptoms):

Discharge _____ Vaginal Dryness _____ Headache _____ Nausea _____ Constipation _____ Diarrhea _____

Swollen Breasts _____ Mood swings _____ Ravenous appetite _____ Poor appetite _____ Hot flashes _____

Night sweats _____ Increased libido _____ Decreased libido _____ Insomnia _____