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PERSONAL HEALTH INFORMATION

Instructions

If this is your first appointment with this office then please, fill in all applicable information using IE or Word on your computer. Then print this form and write in any information requiring pen (i.e.areas of pain on the 2nd page Image and the Consent Form). Bring the form with you the day of your appointment. If you don't have ability to fill the form out with your computer then print it and fill it out by hand. **Call (904) 739-5808 OR 1-877-436-9858 for an appointment.**

PERSONAL DATA

Date:

Phone – Day: ______ Phone – Eve: ______ Cell Phone:

Name: ______ Email: ______

Address: ______ City/State/Zip: ______

Referred by: ______ Age:______ Birthday: ______

Occupation/Employer: ______ Married ______ Single ______ Female ______ Male ______

Primary Health Care Provider: ______ Phone: ______

Permission to consult with primary provider? Please initial if yes. _____ Yes _____ No _____

Emergency contact: _____ Phone: _____

HISTORY / TREATMENT INFORMATION

Have you ever received a professional Acupuncture, Massage Therapy or Body Work before? Yes: ______ No: ______

If yes, what kind? ______ How often? ______

What results do you want from your session today? ______

What is your Major area or concerns? ______

When did you first notice it? ______ What brought it on? ______

What activities aggravate it? ______ Is this condition getting worse? Yes No

Does it interfere with work? ______ sleep? _____ recreation? ______

What do you believe is wrong with you? ______

What have you done to get relief? ______

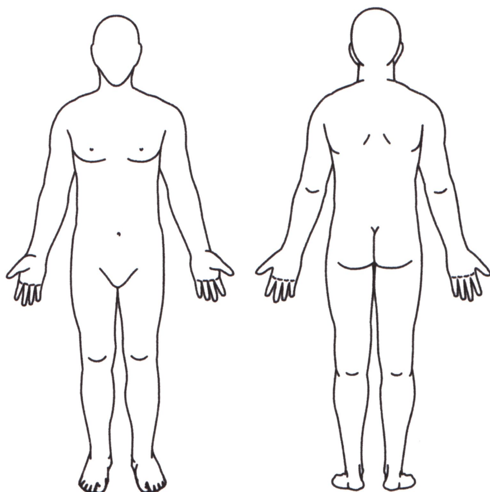
Has there been a medical diagnosis? ______ exam? ______ blood work? ______ x-rays? ______ other? ______

What was the diagnosis? ______ By whom? ______

Other areas of pain or concern: ______

Please, put an X next to the areas of your body that you may experience pain or discomfort:

ALL _____ back _____ legs _____ buttock _____ abdomen _____ chest _____ neck _____ head _____ face _____
arms _____ feet _____ other _____



MARK ON FIGURE WITH PEN AFTER YOU PRINT THIS DOCUMENT ALL AREAS OF:

Pain, tenderness with O's
Numbness, tingling with ZZ's
Swelling, stiffness with X's
Scars, bruises, open wounds with HH's

Rate Severity of Symptom areas from 1-10

(1= I feel like a new born baby, 10 = put me out of my misery)

1 2 3 4 5 6 7 8 9 10

HEALTH HISTORY

Please answer the following questions to the best of your ability. These questions are asked to help enhance and create effective, safe, and educational sessions. All information shared on this form or during sessions is confidential and will not be share with any other health professional unless the client gives written or verbal consent.

Please click on anything applicable and mark with an X:

_____ Headaches
_____ Shooting pains in head
_____ Sinus trouble
_____ Loss of smell
_____ Loss of taste
_____ Tightness in throat
_____ Thyroid trouble
_____ Face flushed
_____ Twitching of face
_____ Loss of memory
_____ Fatigue
_____ Depression
_____ Head feels to heavy
_____ Dizziness
_____ Fainting
_____ Loss of balance
_____ Ringing in ears
_____ Wear glasses
_____ Light bother eyes
_____ Hay fever
_____ Shortness of breath
_____ Asthma
_____ Excess perspiration
_____ Cold sweats

_____ Muscles spasms in neck
_____ Grating in neck
_____ Tightness in shoulder muscles
_____ Neuritis in shoulders & arms
_____ Pins & needles in arms & hands
_____ Cold hands
_____ Epilepsy or other seizures
_____ Tuberculosis
_____ Heart pain
_____ Heart palpitations
_____ Heart attack
_____ High blood pressure
_____ Low blood pressure
_____ Anemia
_____ Blood clots, phlebitis
_____ Hemophilia
_____ Rheumatic fever
_____ Nervous stomach
_____ Stomach trouble
_____ Ulcers
_____ Nervousness
_____ Inner tension
_____ Skin disorder
_____ Sleeping problems

_____ Hepatitis
_____ Liver trouble
_____ Gallbladder trouble
_____ Indigestion
_____ Intestinal gas
_____ Constipation
_____ Bladder trouble
_____ Diabetes
_____ Cancer
_____ HIV
_____ Painful joints
_____ Swollen joints
_____ Arthritis
_____ Herniated or bulging disk
_____ Pinched nerves in back
_____ Pins & needles in legs
_____ Swollen ankles
_____ Cold feet
_____ Pains in legs & feet
_____ Sciatica
_____ Numb hands or feet
_____ Varicose veins
_____ Other:

Previous operations _____

Previous broken bones _____

Previous accidents or injuries _____

Currently, or have you at any time within the last 12 months been under the care of a physician? _____

Please explain for what condition? _____

Are you taking any medications: (list them) _____

Laxatives _____ Sedatives _____ Sleeping Pills _____ Insulin _____ Blood Thinners _____ Pain pills type _____

Vitamins _____ Herbs _____ Minerals _____ Birth control pills _____ Hormone Replacement _____ Other _____

Indicate the following habits with: H-heavy M-moderate L-light N-none

Alcohol _____ Coffee _____ Tea _____ Tobacco _____ Colas _____ Sugared products _____

Artificial Sweeteners _____ White Flour products

Do you exercise? _____ How many times per week? _____ For how long? _____

How many ounces of water do you drink per day? _____

Do you stretch at all throughout your day? _____ Describe _____

Please read, date, and sign the following:

Payment is due at the time of session.
Payment fees are as follows: $ 125.00 - $150.00 / 1 ½ hours; $75.00 / 1 hour; $40.00 / ½ hour.
If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone. If I miss a scheduled appointment without giving 24-hour notice, I agree to pay any missed appointment charge applicable.

Consent for Acupuncture

Name ____
Signature Date

Parent/Guardian consent for Acupuncture of an individual under the age of 18

I, ________________________________, am the parent or legal guardian of____________________________
Legal parents of guardian name Name of minor

____
Signature of Parent/Guardian **Date**