

Heritage Health Acupuncture Intake Form

Name _____ Today's Date _____ Date of Injury _____

Hm Phone _____ Wk Phone _____ Cell Phone _____

Home Address _____ City/State _____ / _____ Zip Code _____

Employer _____ Occupation _____

Date of Birth _____ Marital Status: _____

Emergency Contact _____ Relationship _____ Phone _____

Who may we thank for referring you to our office? _____

If you found us in the yellow pages, do you remember which one? _____

Is your visit due to an auto accident? Yes/No Is your visit due to another accident (ex. work)? Yes/No

What is your major concern today? _____

Have you received acupuncture before? _____ If yes, when was your last _____
treatment _____

How would you describe your discomfort? _____

Intensity: _____ mild _____ moderate _____ severe _____ other: _____

Duration: _____ constant _____ intermittent _____ with certain motions _____

Medical History (Please circle any that you have experienced)

ADD	Cancer	Hepatitis	Numbness/Tingling
Anxiety	Concussion	High Blood Pressure	Sinus Trouble
Arthritis	Diabetes	Irritable Bowel Syndrome	Stress
Asthma	Digestive Disturbances	Multiple Sclerosis	Tuberculosis
Backache	Epilepsy	Muscular Dystrophy	

Have you been treated by a physician for any health conditions in the last year? Yes/No

If so, please describe _____

Blood Pressure: What is your most recent blood pressure reading? _____ / _____ When was this taken? _____

Childhood Illness (Please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

Others: _____

Lifestyle:

a. Do you typically eat at least three meals a day? Y N If no, how many? _____

b. Exercise Routine: _____

c. How many hours per night do you sleep? _____ Do you wake rested? Y N

d. Occupation: _____ Employer: _____ Hours/Week: _____

e. Do you smoke cigarettes? Y/N If yes, how long? _____ How much? _____

f. Do you consume alcohol?

Y/N If yes, what kind? _____ How often? _____

g. Do you use recreational drugs? Y/N if yes, what kind? _____ How often? _____

h. Do you drink caffeine?

Y/N If yes, what kind? _____ How much? _____

i. Have you experienced any traumas? Y N Explain: _____

j. How much water do you drink per day? _____

Do you have insurance? Yes/No If no, how will you be paying today? Cash ___ Check ___ Credit Card ___

If yes, we will need to make a copy of your insurance card.

*If you have Great West Insurance, we will need your Social Security Number _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that this office will prepare my necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I permit this office to endorse co-issued remittance for the conveyance of credit to my account. I hereby authorize Heritage Health and whomever they may designate as their assistants to administer treatment, as they do deem necessary. I authorize the release of my information acquired in the course of my examination or treatment. I certify that the above information is true and correct. I will notify you of any changes in my status or the above information.

Signature

Date

Signature of Parent (if minor)

Date