Acupuncture Case History/Patient Information

Date:_____ Patient #_____ **Doctor: Debbie Moore, LAc DC**

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ Cell Phone:_____

Age:_____ Birth Date:_____ Race:_____ Marital Status: Married Single Widowed Divorced

Occupation:_____ Employer:_____

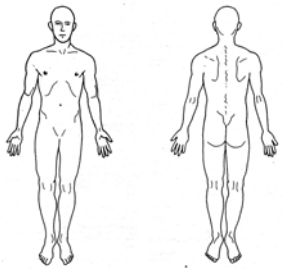
Name of Emergency Contact:_____Phone:_____

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

Medical Doctor (within 60 minutes of this office):_____City:_____

MISSISSIPPI LAW states that we must update your medical doctor regarding your care at this office? Initial Here _____

HISTORY OF PRESENT ILLNESS:



Chief Complaint: Purpose of this appointment:_____

Indicate Location of Pain or Area of Concern on Figure at Right →>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>→

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Attorney's Name and Phone #_____

Days lost from work/school:_____ Date of last medical examination:_____

MEDICAL HISTORY

Check symptoms **N= feeling this right now, M=within the last 30 days, Y= within the last year**

WATER (KIDNEY) ELEMENT

N M Y

☐☐☐ Hearing Loss
☐☐☐ Dizziness
☐☐☐ Low Back Pain
☐☐☐ Neck Pain
☐☐☐ Sinus Congestion
☐☐☐ Edema
☐☐☐ Darkness under eyes
☐☐☐ Emotional Instability
☐☐☐ Aversion to Cold
☐☐☐ Hair Thinning
☐☐☐ Hair Loss
☐☐☐ Premature Gray Hair
☐☐☐ Frequent Urination
☐☐☐ Kidney Stones
☐☐☐ Perspires very easily
☐☐☐ Weakness Legs/Knees
☐☐☐ Asthmatic Cough
☐☐☐ Rapid Weight Change
☐☐☐ Loose Teeth
☐☐☐ Reduced sexual energy
☐☐☐ Thyroid Problems

WOOD (LIVER) ELEMENT

N M Y

☐☐☐ Headaches
☐☐☐ Migraines
☐☐☐ Noise in the Ears
☐☐☐ Poor Eyesight
☐☐☐ Eye Infections
☐☐☐ Pink Eye
☐☐☐ Dry Eyes
☐☐☐ Eczema
☐☐☐ Shingles
☐☐☐ Herpes Simplex
☐☐☐ Warts
☐☐☐ Nervousness
☐☐☐ Convulsions
☐☐☐ Spasms
☐☐☐ Irritability
☐☐☐ Constipation
☐☐☐ Hemorrhoids
☐☐☐ Hepatitis
☐☐☐ Ulcers
☐☐☐ Vomiting
☐☐☐ Gallstones
☐☐☐ Can't make decisions
☐☐☐ Fullness Below Ribs
☐☐☐ Shoulder/Neck Tension
☐☐☐ Insomnia 11pm-3am

FIRE (HEART) ELEMENT

N M Y

☐☐☐ Dry Scalp
☐☐☐ Skin Eruptions
☐☐☐ Skin Rashes
☐☐☐ Cysts
☐☐☐ Tumors
☐☐☐ Ear Infections
☐☐☐ Sore Throat
☐☐☐ Tonsillitis
☐☐☐ Lymphatic Swelling
☐☐☐ Hot Palms/Soles
☐☐☐ Hot Hands/Feet
☐☐☐ Heart Palpitations
☐☐☐ Aversion to Heat
☐☐☐ Bitter Taste in Mouth
☐☐☐ Gum Problems
☐☐☐ Nose Bleed
☐☐☐ Facial Redness
☐☐☐ Itching Skin
☐☐☐ Burning Skin
☐☐☐ Thirsty Often
☐☐☐ Vivid Dreams
☐☐☐ Dark Urine
☐☐☐ Night Sweats

EARTH (SPLEEN) ELEMENT

N M Y

☐☐☐ Indigestion
☐☐☐ Flatulence
☐☐☐ Food Allergy
☐☐☐ Stomachache
☐☐☐ Stomach Ulcer
☐☐☐ Diarrhea
☐☐☐ Anemia
☐☐☐ Halitosis/Bad Breath
☐☐☐ Sores in Mouth
☐☐☐ Heart Burn
☐☐☐ Strong Appetite
☐☐☐ Weak Appetite
☐☐☐ Nausea
☐☐☐ Abdominal Boating
☐☐☐ Low Body Weight

METAL (LUNG) ELEMENT

N M Y

☐☐☐ Bronchitis
☐☐☐ Asthma
☐☐☐ Shallow Breathing
☐☐☐ Cough
☐☐☐ Sinus Congestion
☐☐☐ Nasal Infections
☐☐☐ Sinus Allergies

OTHER

N M Y

☐☐☐ Fatigue
☐☐☐ Joint Pain
☐☐☐ Sciatica/Nerve Pain
☐☐☐ Cold Hands and Feet
☐☐☐ Tendonitis
☐☐☐ Bursitis

WOMEN ONLY

(Check if applicable)

Mensus
Age Started ____
Age Stopped _____
☐Irregular Cycle
☐Painful ☐Clotting
Color ☐Dark ☐Light
Flow ☐Heavy ☐Light
☐Water Retention
☐Painful Breasts

Pregnancies
pregnancies ___# Children ___
miscarriages _____
Stillbirths_____
☐Think you are Pregnant
☐Infertility (suspect/known)

Vaginal Discharge
☐Liquid ☐Thick
☐Yellow ☐White ☐Green
☐Odor _____

MEN ONLY

(Check if Applicable)

☐Low Sex Drive ☐Impotence
☐Premature Ejaculation
☐Seminal Emission
☐Discharge ☐Genital Pain
☐Other _____

Have you ever (in your entire life) had any:

Major Illnesses ☐No ☐Yes Describe _____

Hospitalizations ☐No ☐Yes Describe _____

Injuries/ Falls ☐No ☐Yes Describe _____

Auto Accidents or Fender Benders ☐No ☐Yes When _____

Women Circle Surgeries Ovaries Uterus Tubes Breast Date(s) _____

Have you been treated for any health condition by a physician in the last year? ☐No ☐Yes For What _____

What prescribed or purchased medications are you taking? _____

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages ☐No ☐Yes If so, how much per week?_____

Do you use any tobacco products or smoke ☐No ☐Yes If so, # packs per day: _____# of Years _____

Do you take vitamin supplements☐No ☐Yes If so, please list:_____

Do you consume caffeine ☐No ☐Yes Coke Coffee Tea Other How much per day:_____

Do you exercise ☐No ☐Yes If yes, # days/week _____ # Minutes/day_____

What are your hobbies?_____

What is your typical stress level? ☐High ☐Medium ☐Low How do you fell like you handle it? ☐Well ☐Poorly ☐Unsure

FAMILY HISTORY:

Parents:

Check if applicable to you: ☐As an adopted child, little is known of birth parents or family.

Father: ☐living ☐deceased Current age if still living:_____ Cause of death if deceased:_____

Mother: ☐living ☐deceased Current age if still living:_____ Cause of death if deceased:_____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother, **O**ther):

F M S B O Tuberculosis	F M S B O Kidney Disaese	F M S B O Epilepsy
F M S B O Diabetes	F M S B O Liver Disease	F M S B O High Blood Pressure
F M S B O Stroke	F M S B O Mental Illness	F M S B O Scoliosis
F M S B O Arthritis	F M S B O Heart Disease	F M S B O Other _____
F M S B O Cancer	F M S B O Lung Disease	F M S B O Other _____
F M S B O Asthma	F M S B O Emphysema	F M S B O Other _____

INFORMED CONSENT TO TREAT: I understand and am informed that, in the practice of acupuncture there are some risks to treatment, including but not limited to drowsiness occurs after treatment in a small number of patients, and, if affected, you are advised not to drive; minor bleeding or bruising occurs after acupuncture in about 3% of treatments; pain during treatment occurs in about 1% of treatments; symptoms can get worse after treatment (less than 3% of patients). You should tell your acupuncturist about this, but it is usually a good sign; fainting can occur in certain patients, particularly at the first treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. ***I understand that I may revoke this consent at anytime verbally or in writing to the doctor. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content***, and by signing below I agree to the procedures outlined by my acupuncturist in my treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the acupuncturist, chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____