Acupuncture by Alana

Alana Hammer, MS, Dipl.OM, LAc.

Important! Complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

PERSONAL INFORMATION

Today's Date __ //___//___

First Name _____ Last Name _____ Middle Initial _____

Date of Birth ____//____//____ Age _____ Gender M F Height _____ Weight _____

Email Address _____

Street Address _____

City _____ State _____ Zip Code _____

Phone (day): ( ) _____
Home ( ) _____
Work ( ) _____
Mobile ( ) _____

Phone (eve): ( ) _____
Home ( ) _____
Work ( ) _____
Mobile ( ) _____

Emergency Contact (Name & Number): _____

Partner Contact (if not same as emergency contact): _____

Referred by? _____

Primary Physician: _____

Telephone: ( ) _____

Physician's Address (or name of clinic/hospital): _____

Insurance Company: _____

Insured's Name (if not you): _____

Insurance Company Address: _____

Relationship to Patient: _____ Telephone: ( ) _____

Policy Group or FECA Number: _____ Insured ID Number: _____

Social Security Number: _____

Employment Status: ❒ Full-time ❒ Part-time ❒ Retired ❒ Unemployed ❒ Student ❒ Self-employed

Note on Insurance:
Full payment is due at the time of service. Upon request, a Superbill will be provided. A Superbill is an invoice using standardized codes for treatments received, which you can submit directly to your insurance company for reimbursements. Please call your insurance carrier to find out about your insurance plan's coverage for acupuncture and related services.

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TREATMENT

What issue(s) would you like treated?

How long since onset? _____

What makes it better?_____

What makes it worse? _____

Have you received any treatments for this health issue? ❒ Yes ❒ No Please describe.

Have you ever had acupuncture before? ❒ Yes ❒ No If so, for what condition(s)?

Are you presently being treated for any (other) medical conditions? ❒ Yes ❒ No Please describe.

Please list/describe other health concerns, in order of importance.

1.

2.

3.

DIET & EXERCISE

Are you on a special diet? (e.g. vegetarian, vegan, low carb, raw, Atkins, Zone, etc…)

Typical Daily Diet

Breakfast: _____

Snacks: _____

Lunch: _____

Dinner: _____

Average daily water intake (# of glasses): _____

Do you exercise? ❒ Yes ❒ No If yes, Please describe.

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MEDICATIONS

Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops, nose sprays, and topical creams.
NOTE: If need more space, use back of page.

1.
2.
3.
4.
5.
6.
7.

PRESCRIPTIONS

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

SUPPLEMENTS

Supplement Name	Purpose	How Long	Dose	How Often	Last Dose

			Amount	Describe
Caffeinated Coffee	❒ Yes	❒ No		
Caffeinated Tea	❒ Yes	❒ No		
Cigarettes	❒ Yes	❒ No		
Marijuana	❒ Yes	❒ No		
Other Drugs	❒ Yes	❒ No		

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Men's one a day

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PERSONAL & FAMILY MEDICAL HISTORY

Use a “C” for current problems
Use a “P” for past problems
Leave blank if not applicable.
Please list age of relatives or age when they passed on.

	YOU	MOTHER	FATHER	SISTER(S)	BROTHER(S)	CHILDREN
AGE						
AIDS/HIV						
Alcohol						
Allergies						
Anxiety						
Anorexia/Bulimia						
Arthritis						
Asthma/Hay Fever/Allergy						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Depression						
Diabetes						
Digestive Trouble						
Headaches						
Heart Trouble						
Hepatitis						
High Blood Pressure						
Immune Disorder						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Neck Pain						
Thyroid Disorder						
Tobacco						
Weight Problem						
Other:						

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SYMPTOMS

For current symptoms, rate its severity from 1-5 (5 being the worst).
For past symptoms, circle { P }
If Not Applicable, leave blank

LIVER / GALLBLADDER

Severity	Symptom
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Irritability / Anger
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Depression
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Stress / Tension
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Headaches / Migraines
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Red / Dry / Itchy eyes
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Gall stones
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Dizziness
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Blurred vision
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Feeling of lump in throat
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Clenching of teeth at night
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Muscle Cramp / Twitch
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Pain / Tight in Joints / Neck / Shoulder
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Poor circulation
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Soft / Brittle Nails
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Emotional eating
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Bad taste in mouth
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Craving sour foods

SPLEEN / STOMACH

Severity	Symptom
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Body heaviness
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Fatigue
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Difficulty getting up in morning
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Muscle weakness / tired
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Edema (swelling)
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Easy to bruise / bleed
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Bad breath
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Nausea / vomiting
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Difficulty digesting fatty foods
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Gas / belching
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Hemorrhoids
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Constipation
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Loose stools
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Abdominal pain
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Heartburn / Indigestion
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Over-thinking
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Tendency to gain weight
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Foggy brain
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Craving sweet foods

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For past symptoms, circle { P }
If Not Applicable, leave blank

KIDNEY / URINARY BLADDER

Severity	Symptom
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Urinary problems
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Bladder infection
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Incontinence
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Weak / Pain in low back
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Decreased bone density
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Feeling cold easily
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Cold hands
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Cold feet
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Low Libido (sex drive)
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Excess Libido (sex drive)
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Poor memory
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Loss of Hair
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Hearing problems
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Cavities
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Fear
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Hot flash / Night sweat
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Craving salty foods

LUNG / LARGE INTESTINE

Severity	Symptom
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Dry cough
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Productive cough
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Bloody cough
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Nasal discharge
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Post nasal drip
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Sinus congestion
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Itchy / red / painful throat
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Skin rash / hives
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Snoring
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Grief / sadness
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Short of breath
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Allergies
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Asthma
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Low resistance to colds
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Sneezing
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Mild fever
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Emphysema
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Bronchitis
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Constipation
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	IBS
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Colitis / spastic colon
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Diarrhea
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Craving spicy foods

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For past symptoms, circle { P }
If Not Applicable, leave blank

HEART / SMALL INTESTINE

Severity	Symptom
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Heart palpitations
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Chest pain
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Insomnia / Sleep problems
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Easily startled
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Restless / vivid dreams
{ 1 } { 2 } { 3 } { 4 } { 5 } { P }	Craving bitter foods

PRACTITIONER NOTES

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