

Welcome to Anatomy Power Acupuncture

Mind, Body, Spirit for a Balanced Life

Date: _____

Patient Information

Patient Name: _____

Address: _____

City: _____

State/Zip: _____

Birthdate: _____

SSN: _____

Occupation: _____

Gender/Circle One: Female / Male

Whom may we thank for referring you? _____

Phone Numbers

Cell Phone: (____) _____

Home Phone: (____) _____

Email: _____

Emerg Contact: (____) _____

Emerg Contact Name: _____

Family History

Please check any that apply to your family:

Cancer Seizure Kidney Disease Diabetes

Heart Disease High Blood Pressure Ulcers

Osteoarthritis Alcoholism Arthritis Other

Patient Condition

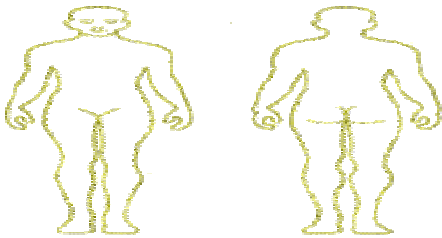
Reason for visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? _____

Mark an X on the picture where you have pain, numbness or tingling or any symptom.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____



Type of pain: Sharp, Dull, Throbbing,
 Numbness, Aching, Shooting, Burning,
 Tingling, Cramps, Stiffness, Swelling,
 Other: _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: Daily Routine,
 Work, Sleep, Recreation

Activities or movements that are painful to perform:
—Sitting, Standing, Walking, Bending

Anything else we should know? _____

Insurance Information

Who is responsible for this account? _____

Relationship to Patient: _____

Insurance Company: _____

Group #: _____

Assignment and Release

I certify that I have healthcare insurance with [Company Name] _____

and assign directly to Anatomy Power all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent or Guardian

Please print name of Patient, Parent or Guardian

Date

Relationship to Patient

Accident Information

Is this condition due to an accident? Yes No

Date of the accident: _____

Type of accident: Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker's Comp

Attorney Name (if applicable): _____

HEALTH HISTORY

What treatment have you already received for your condition? Chiropractic Medications Surgery Physical Therapy
 Acupuncture

Date of last: Physical Exam _____ Medical Doctor Visit _____ Please CHECK all that apply to your condition:

GENERAL	HEAD & EENT	HEART & LUNG	GI	REPRODUCTIVE
<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Headaches	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Bad Breath	FEMALE:
<input type="checkbox"/> Heavy Appetite	<input type="checkbox"/> Migraines	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Constipation	<input type="checkbox"/> Irregular Cycles
<input type="checkbox"/> Poor Sleep	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Pain or Cramps	<input type="checkbox"/> Breast Lumps/Tender
<input type="checkbox"/> Heavy Sleep	<input type="checkbox"/> Facial Pain	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Rectal Pain	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bloody Stools	<input type="checkbox"/> Premenstrual Problems
<input type="checkbox"/> Bleed/Bruise Easily	<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Clotting/Bleeding
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Spots in Eyes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Menopause Difficulty
<input type="checkbox"/> Tremors	<input type="checkbox"/> Tearing/Dryness	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Changes in Appetite	<input type="checkbox"/> Painful Periods
<input type="checkbox"/> Vertigo	<input type="checkbox"/> Earaches	<input type="checkbox"/> Stroke	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Vaginal Sores
<input type="checkbox"/> Colds Hands or Feet	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heartburn	MALE:
<input type="checkbox"/> Cold Back	<input type="checkbox"/> Poor Hearing	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sexual Difficulties
<input type="checkbox"/> Peculiar Taste/Smell	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Swelling of Ankles	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Prostrate Problems
<input type="checkbox"/> Cold Abdomen	<input type="checkbox"/> Lips/Tongue Sores	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Testicular Pain
<input type="checkbox"/> Fevers	<input type="checkbox"/> TMJ/Jaw Problems	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Penile Discharge
<input type="checkbox"/> Chills	<input type="checkbox"/> Gum Problems	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Frequent Urination	
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Teeth Grinding	<input type="checkbox"/> Cold Hands/Feet	<input type="checkbox"/> Impaired Urination	
<input type="checkbox"/> Sweats Easily	<input type="checkbox"/> Teeth Problems	<input type="checkbox"/> Heart Murmurs	<input type="checkbox"/> Blood in Urine	
<input type="checkbox"/> Cravings	<input type="checkbox"/> Dry Throat	<input type="checkbox"/> Rheumatic Fever		
<input type="checkbox"/> Chronic Infections	<input type="checkbox"/> Dry Mouth	<input type="checkbox"/> Blood Clots		
<input type="checkbox"/> Localized Weakness	<input type="checkbox"/> Copious Saliva			
<input type="checkbox"/> Poor Coordination	<input type="checkbox"/> Hay Fever			

SKIN & HAIR	NEURO	ENDOCRINE	LIFESTYLE	DIET
<input type="checkbox"/> Rashes / Pimples	<input type="checkbox"/> Seizures	<input type="checkbox"/> Hypothyroid	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Low Appetite
<input type="checkbox"/> Dandruff	<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Tobacco	<input type="checkbox"/> Coffee
<input type="checkbox"/> Hives	<input type="checkbox"/> Poor Memory	<input type="checkbox"/> Hyperthyroid	<input type="checkbox"/> Marijuana	<input type="checkbox"/> Sugar
<input type="checkbox"/> Loss of Hair	<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Drugs	<input type="checkbox"/> Salty Foods
<input type="checkbox"/> Itching	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Frequency of Use: _____	<input type="checkbox"/> Soft Drinks
<input type="checkbox"/> Eczema	<input type="checkbox"/> Vertigo / Dizziness	<input type="checkbox"/> Feeling Hot or Cold	<input type="checkbox"/> Regular Exercise: _____	<input type="checkbox"/> Artificial Sweetener
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Loss of Balance		<input type="checkbox"/> How Often? _____	<input type="checkbox"/> Greasy/Fried Foods

Are you pregnant? Yes No Due Date: _____

Please describe any that apply to you:

Falls _____	Date _____
Head Injuries _____	Date _____
Broken Bones _____	Date _____
Disocations _____	Date _____
Surgeries _____	Date _____

MEDICATIONS	ALLERGIES	VITAMINS
Drug Name		
Condition being treated		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____