Golden Point Acupuncture

Confidential **Date:**_____

Patient Information

Patient_____
Age: _____Date of Birth:_____
Height _____ Weight _____Gender: _____
Address_____
City _____State_____Zip_____
Marital Status: ❑ Single ❑ Married ❑ Separated
❑ divorced ❑ Widowed
Occupation_____
Employer_____
Name of Physician _____Tel:_____
OK for me to contact? ❑ Y ❑ N

Who Referred You_____

Insurance

Skip this if you provide insurance card for copy

Primary Insurance
Insurance Company_____
Patient's Relationship to Subscriber_____
Subscriber's Date of Birth_____
Group Number_____
Policy Number_____
Secondary Insurance
Insurance Company_____
Subscriber's Name_____
Subscriber's Date of Birth_____
Patient's Relationship to Subscriber_____
Group Number_____
Policy Number_____

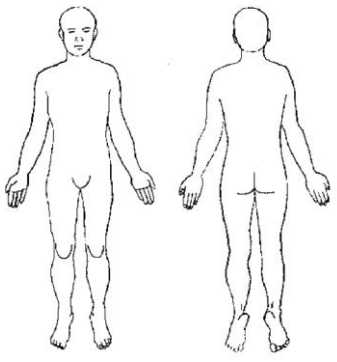
Contact Information

Tel Home _____ Cell_____
In Case of Emergency, Contact
Name _____Relationship_____
Tel Home _____ Cell_____

Health Condition

Main Health Issue _____

Is condition Due to Accident? ❑ Y ❑ N Date _____ What happened?_____
How long have you had this condition? _____The onset was ❑ Sudden or ❑ Gradual
What were the circumstances? _____
Any medical diagnosis _____
Please mark X in the picture of your condition area.
Pain (please circle): Sharp / Dull / Throbbing / Numbness / Aching /
Shooting / Burning /Tingling Cramps / Stiffness, Other: _____
How often do you have the pain: all day / AM / PM / while sleeping / come & go
What kinds of treatment or therapy have you tried? _____
How has this condition affected your daily activities? _____
What makes this condition better? _____worse? _____
Rate the intensity of the physical discomfort of this condition from 1 to 10, 1 (least painful) 10 (Severe pain) _____



Medical History

Any Blood Clotting Issues? _____ Are you taking blood thinner? ❑ Yes ❑ No
Major Surgery and When:_____
Major illness in the family(father, mother, siblings):_____
Please check off any current or former conditions and include dates as well as any relevant information

❑ AIDS/HIV _____ any neuropathies? _____
❑ Alcoholism/ Drug Abuse _____
❑ Allergies _____ ❑ Anemia _____
❑ Asthma/ Bronchitis _____ ❑ difficulty inhaling ❑ difficulty exhaling
❑ Bell's Palsy _____ ❑Blood clotting disorder _____
❑ Bipolar disorder _____ ❑Cancer/Tumor_____
❑ Chron's Disease & / or Colitis (IBD / IBS) _____
❑ Chronic Fatigue Syndrome (CFIDS)_____ ❑Depression (Major)_____
❑ Diabetes-Type_____ any neuropathies?_____
❑ Eczema _____ ❑ Emphysema _____
❑ Endometriosis _____ ❑Fibroids_____
❑ Fibromyalgia_____ ❑Gallstones_____
❑ Heart Disease_____
❑ Hepatitis A/B/C - please specify _____
❑ Hernia _____ ❑ Herpes - Type _____
❑ Hypertension _____ ❑Hypoglycemia_____
❑ Irritable Bowel Syndrome (IBS)_____ ❑ Inflammatory Bowel Disease (IBD) _____
❑ Joint Replacement_____ ❑Kidney Stones and /or Disease_____
❑ Lupus_____ ❑Lyme disease _____
❑ Lymph Nodes removed - where? _____ can you have injections on that side? _____
❑ Mitral Valve Prolepses_____ ❑Mood Disorder_____
❑ Multiple Sclerosis _____ ❑Organ Transplant/ Removed _____
❑ Osteoarthritis _____ ❑Osteoporosis_____
❑ Pacemaker _____
❑ Parkinson's Disease_____ ❑Pelvic Inflammatory Disease_____
❑ Polio _____spinal segments involved_____
❑ Psoriasis_____ ❑PTSD (Post-Traumatic Stress Disorder)_____
❑ Reflux Esophagistis (GERD)_____ ❑Rheumatic or Scarlet Fever _____
❑ Rheumatoid Arthritis _____ ❑ Seizures and/or Epilepsy _____
❑ Shingles_____ ❑Stroke_____
❑ Schizophrenia_____ ❑Thyroid disease _____
❑ Tuberculosis _____ ❑Trigeminal Neuralgia_____
❑ Other _____

Medication	Vitamin / Supplement	Exercise
		❑ None
		❑ Moderate
		❑ Daily
		❑ Heavy

Habits	Allergies	Emotional Issues
❑Smoking Packs / Day _____		❑ Stress ❑ Anxiety
❑Alcohol Drinks / Week _____		❑ Depressed ❑ Insomnia
❑Coffee/Caffeine Drinks Cups /Day ____		❑ irritability/short temper
		❑feeling overwhelmed ❑ extreme mood swings
		❑ poor memory ❑ difficult concentration

Women	Men
Are you Pregnant? _____ Period Normal ❑ Y ❑ N ❑ Menopause Any Issues: _____	Sexual Function Normal ❑ Y ❑ N Any Issues: _____

Other	
Bowel Movement: ❑Constipation ❑ Diarrhea ❑ Normal Energy Level: ❑ High ❑ Low ❑ Normal Appetite: ❑ Good ❑ not good ❑ Normal Generally feel: ❑ Hot ❑ Cold ❑ Normal Thirsty: ❑ Always ❑ Normal Prefer: ❑ Hot drinks ❑ cold drinks Sleep: ❑ Trouble falling asleep ❑ Trouble staying asleep	

Thank you for the patient and honesty. These information will help me to understand your health and it is valuable to help me to formulate the best treatment plan for you.