Golden Phoenix Health

Appointment Date:

General Information

Name ______________________________ Date __________
First Last

Address ____________________ City ______________ State ______ Zip ________

Married Single Partner Divorced Widowed

Age ______ Date of Birth ____________ Preferred Phone ____________________

Email ______________________________
I DO NOT wish to receive educational and promotional notices ☐

Occupation ____________________ Employer ____________________

In case of emergency, call ______________________________
Name Number Relationship

Primary Physician Name ____________________ Phone Number ____________________

Have you had Acupuncture or Orential medicine before? No Yes For what? ____________________

Are there any other therapies which you are involved in? What kind? ____________________

How did you find out about us? ______________________________

For Minors: List guardian's name and address ______________________________

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Financial Arrangements

How do you plan to handle your account? (Check one) ☐ Cash ☐ Check ☐ Visa ☐ Master Card

Cancellation Policy

The time that is scheduled for you is not avaible to anyone else. A late cancellation fee equal to the cost of your treatment is charged per occurrence if there is less than 24 hours notice of cancellation or request to reschedule (unless it is an emergency).

Insurance Information

Insurance Company ______________________________ Contact # ____________________

ID # ____________________ Co-pay $ ____________________ Visit # ____________________

Covered % ____________________ Date called ____________________ Contact Name ____________________

Focus

What is your primary reason for seeking care at our office?____________________

What was the initial cause?____________________

When did it begin?____________________

What makes it worse?____________________

What makes it better?____________________

Does this interfere with your daily activities?

○ Work	○ Sexually	○ Standing	○ Other__________
○ Sleep	○ Recreation	○ Relationships	__________
○ Walking	○ Stretching	○ Social Life	__________
○ Sitting	○ Bending	○ Emotional	

Are you intrested in:

○ Pain Relief	○ Performance Care	○ Maintance Care	○ Other__________
○ Preventative Care	○ Holistic Health	○ Stress Relief	__________
○ Oriental Nutrition	○ Medical Qi Gong	○ Herbal Therapy	__________

Pain

Please indicate areas of pain / tension / tightness / discomfort on the chart.

Pain intensity levels (describe which fits)
No pain Moderate pain Severe pain Terribe pain

Sleeping
No problem Mildly disturbed Greatly disturbed Can’t sleep

Work- can do
Usual work 25% of work 50% of work No work

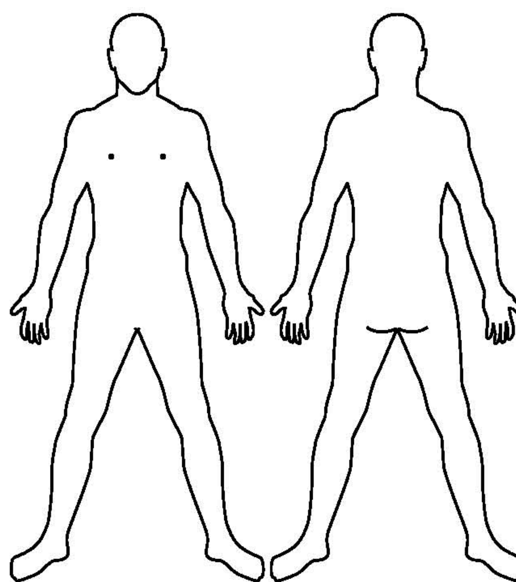
Frequency of pain
25% of time 50% of time 75% of time 100% of time

Walking
Can walk any distance Pain after 1/2 mile Can’t walk

Travel
No problem Moderate pain Severe pain

Recreation- can do
All activities Some activities No activities

Sitting
No pain Some pain Can’t sit



Lifestyle Factors

List any past or planned surgeries ______________________________

Approximately how much water do you drink a day?______________ How much caffeine do you drink? ______________

List any significant trauma. When did it occur? (auto accident, falls, emotional, etc...)______________________

List exercise and sport activities you have been or are currently involved in: ______________________

Medications taken within the last two months?______________________________

Do you use tabacco? No Yes If so what kind?__________ How much? ______________________

How many alcoholic beverages do you typically drink in a week?______________________

What are your indulgences?______________________________

What are your hobbies & pleasures?______________________________

Do you dream? No Yes

Do you have a high point of the day? No Yes When______________________________

Do you have a low point of the day? No Yes When ______________________________

Do you have a pacemaker or other electronic implant? No Yes If yes, since when? ______________________

Are you pregnant? No Yes If yes, how long?______________________________

What Are your health goals? ______________________________

Medical History

Please indicate if you have or had any of the following conditions:

○ Pneumonia	○ Drug reaction	○ Mental breakdown	○ Gonorrhea/Herpes	○ Cancer
○ Tuberculosis	○ Heart attack	○ Jaundice	○ HIV/Aids	○ Mental illness
○ Hepatitis	○ Blood transfusion	○ Parasites	○ High/low blood pressure	○ Hypo/hyper thyroid
○ Diabetes	○ Anemia	○ Measles		○ Premature graying
○ Epilepsy	○ Arthritis	○ Mumps	○ Heart disease	○ Seizures
○ Kidney stones	○ Obesity	○ Syphilis	○ Gout	○ Multiple sclerosis

Family History

○ Cancer	○ Stroke	○ Hepatitis	○ Seizures	○ Diabetes
○ Asthma	○ High blood pressure	○ Allergies	○ Heart attack	○ Other__________

Signs/Symptoms

Please check any symptoms that you have had in the last 3 months (circle any that are severe)

General
- ○ Sweats easily during the day
- ○ Night sweats
- ○ Bleeding/bruise easily
- ○ Change in appetite
- ○ Chills
- ○ Fatigue
- ○ Poor sleep
- ○ Peculiar tastes
- ○ Weight gain/loss
- ○ Undiagnosed pain
- ○ Fever
- ○ Strong thirst (hot or cold)
- ○ Cravings
- ○ Sudden energy drop what time day______

Gynocological
- ○ Irregular periods
- ○ Painful periods
- ○ Bleeding between periods
- ○ Vaginal discharge
- ○ Vaginal sores
- ○ PMS
- ○ Clots
- ○ Cramps
- ○ Breast issues
- ○ Fibroids
- ○ Cysts
- ○ Endometriosis

Age of first menses______
Duration of cycle_______
Duration of typical period
pregnancies__________
live births____________
premature births______
miscarrages__________
aborations____________
- ○ Menopause age______
- ○ Birth control how long__________

Date of last menstruation

____

Skin/Hair
- ○ Rashes
- ○ Hives
- ○ Itching
- ○ Eczema
- ○ Pimples
- ○ Ulcerations/boils
- ○ Skin fungal infection
- ○ Recent moles
- ○ Psoriasis
- ○ Loss of hair
- ○ Change in skin/hair texture

HEENT
- ○ Ear aches
- ○ Ringing in ears
- ○ Plugged feeling in ears
- ○ Hearing loss (temporary/permanent)
- ○ Headaches/migraines
- ○ Blurry vision
- ○ Spots in front of eyes
- ○ Redness of eyes
- ○ Itchy eyes
- ○ Eye pain/strain/tension
- ○ Sinus pressure
- ○ Nose bleeds
- ○ Sinus infections
- ○ Nasal congestion
- ○ Sore throat
- ○ Dry throat/mouth
- ○ Mouth sores
- ○ Swollen glands
- ○ Enlarged thyroid
- ○ Sore lips/tongue
- ○ Teeth/jaw clenching/ grinding
- ○ Teeth/gum problems
- ○ Excessive saliva
- ○ Dizziness/vertigo

Cardo, Circulatory
- ○ Chest pain
- ○ Fainting
- ○ Heart palpations
- ○ High/low blood pressure
- ○ Light headedness
- ○ Cold hands/feet
- ○ Numbness
- ○ Poor circulation
- ○ Swelling/edema
- ○ Blood in stools
- ○ Mucus in stools
- ○ Dark stools
- ○ Ordorous stools
- ○ Hemorrhoids
- ○ Rectal pain/itching

Respiratory
- ○ Cough
- ○ Coughing blood
- ○ Shortness of breath
- ○ Asthma
- ○ Sneezing
- ○ Wheezing
- ○ Seasonal allergies
- ○ Chest tightness
- ○ Pain with breathing
- ○ Phlegm Color_______________

Digestive
- ○ Heartburn
- ○ Indigestion
- ○ Acid reflux
- ○ Gas/bloating
- ○ Belching
- ○ Nausea/vomiting
- ○ Poor appetite
- ○ Bad breath
- ○ Constipation
- ○ Laxative use
- ○ Diarrhea
- ○ Abdomal pain/distention
- ○ Intestinal pain/cramps

Genito/Urinary
- ○ Difficulty urinating
- ○ Decreased/increased flow
- ○ Pain upon urnation
- ○ Blood in urine
- ○ UTI
- ○ Waking to urnate
- ○ Urgent/frequent urination
- ○ Genital pain
- ○ Sores on genital
- ○ Kidney stones
- ○ Impotence
- ○ Nocturnal emission
- ○ Increased libido
- ○ Decreased libido
- ○ Premature ejaculation

Neurological/Psychological
- ○ Poor memory
- ○ Anxiety
- ○ Seizures
- ○ Irritable
- ○ Areas of paralysis
- ○ Confusion
- ○ Concussion
- ○ Quick temper
- ○ Depression
- ○ Easily susceptible to stress
- ○ Lack of coordination
- ○ Loss of balance

I agree to the terms. I assert that, to the best of my knowledge, all information herein is correct and complete. I authorize communication between my Acupuncturist and my medical providers to coordinate care.

PATIENT;S SIGNATURE____ Date___________________________

(parent/guardian's signature if client is a minor)