Golden Circle
ACUPUNCTURE

Patient Name: _____

General Information

Today's Date _____

Name _____ Date of Birth _____Age___
First, MI, Last

If minor; Parent/Guardian_____
Full Name Phone#

Contact phone _____ Can leave a message? ___Yes ___No

Email Address _____

Address _____ City _____ State/Zip code _____

Occupation _____ Employer _____

In case of emergency, contact _____
Name Phone # Relation

Primary Physician _____Phone _____ Last physical exam _____

Are you currently under physician care? ___Yes ___No

If yes, what condition _____

Have you had acupuncture treatment or oriental medicine before? ___Yes ___ No

If yes, what condition _____

Are you pregnant? ___Yes ___ No Are you nursing? ___Yes ___ No

Do you require interpretive assistance? ____yes _____ No

Financial Arrangement

Golden Circle Acupuncture in-network for many Healthcare plans. If out-of-work and your insurance carrier provides acupuncture benefit. We will gladly provide you a copy of your bill to submit for reimbursement.
Patients are responsible for payment of copays, coinsurance, deductibles, and all other procedures or treatments not covered by their insurance plan
We accept Cash, Check, HSA and major credit cards.
Insurance carrier:_____ Phone# _____
Subscriber:_____ DOB: _____ ID#: _____
Relation to subscriber: ___ self, _____spouse, _____ dependent

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Cancelation Policy

Your scheduled time is important to you as well as to us. Please provide us at least a 24-hour notice for any changes to your appointment. A charge will apply for inadequate notification of missed appointments or over 15 minutes late of scheduled appointment without notification.

What are the concerns for which you are seeking care? Please list primary concern first

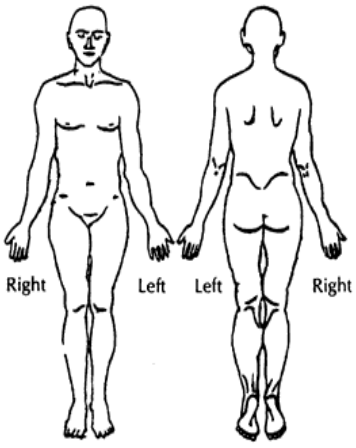
1. _____ Date of initial onset _____
2. _____ Date of initial onset _____
3. _____ Date of initial onset _____
4. _____ Date of initial onset _____

Pain

Please indicate areas where you are experiencing pain/discomfort on the figure below

Does the pain interfere or has an impact on your daily activities, check where applicable?

- ○ Walking
- ○ Sleeping
- ○ Sitting
- ○ Bending
- ○ Socially
- ○ Emotionally
- ○ Work
- ○ Standing
- ○ Stretching
- ○ Recreation
- ○ Sexually
- ○ Others _____



- ➢ Are you currently taking any medication (prescribed or over-the-counter)?

Please List _____

- ➢ Are you currently taking supplements including, vitamins, herbs or? homeopathic remedies?

Please list _____

- ➢ Do you have hypersensitivity or allergy to drugs, food, environmental substances or vegetation? ___ Yes ___ No

Please list and indicate reaction _____

Family History

Please indicate if your mother, father, brother, sister or grandparent had/has any of the following disease(s):

- ○ Anemia
- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Allergies
- ○ Arthritis
- ○ Diabetes
- ○ Heart Disease
- ○ Cancer
- ○ Asthma
- ○ Parkinson's Disease
- ○ Epilepsy
- ○ Stroke
- ○ Glaucoma
- ○ Mental Illness
- ○ Alzheimer's Disease
- ○ Seizures
- ○ Hepatitis
- ○ Cataract
- ○ Organ Transplant
- ○ Other _____

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Medical History

- Have you had any of the following childhood illnesses:

○ Diphtheria	○ Mumps	○ Measles	
○ Scarlet Fever	○ German Measles	○ Rheumatoid Arthritis	○ Others _____

- Have you had any immunization? ___ Yes___ No

- Have you been hospitalized or had surgical procedure(s)? ___ Yes ___ No

_____ Year _____ _____ Year _____

_____ Year _____ _____ Year _____

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

○ Pneumonia	○ Tuberculosis	○ Hepatitis	○ Gonorrhea/Herpes
○ Diabetes	○ Epilepsy	○ Liver disease	○ Syphilis
○ Arthritis	○ Seizures	○ Gallbladder stones	○ HIV/AIDS
○ Cancer	○ Multiple sclerosis	○ Gout	○ Parasites
○ Heart disease	○ Anemia	○ Thyroid problems	○ Mental illness
○ High/Low blood Pressure	○ Circulatory problems	○ Kidney Problems/ Stones	○ Mental breakdown/ emotional trauma
○ Pacemaker or another electronic implant			

Lifestyle

Please check any of the following you have or have had in the past six months

○ Main Interests or hobbies _____	○ Major Traumas	○ Treated for drug dependency	○ Enjoy your work
○ Do you exercise? _____ What kind/frequency? _____	○ Alcohol Beverage What kind/frequency? _____	○ Use tobacco For how long_____ Packs/day _____	○ Spend time outdoors ○ Gardening ○ Sports
○ Average of 6-8 hours of sleep	○ Drink coffee or energy drinks	○ Use recreational drugs	○ Take vacations
○ Have a supportive relationship	○ Drink Soda	○ Food indulgence	○ Enjoy Pets
○ History of abuse	○ Treated for alcoholism	○ Excessive dreams	

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Review of Signs/Symptoms

Please check any of the following you have or had in the past six months

General
- ○ Poor sleep/insomnia
- ○ Dream disturbed sleep
- ○ Fatigue/Low energy
- ○ General hot feet
- ○ General cold feet
- ○ Chills
- ○ Fever
- ○ Poor appetite
- ○ Constant hunger
- ○ Craving
- ○ Unusual taste in mouth
- ○ Low libido
- ○ High stress

Eyes and Ears
- ○ Itchy eyes
- ○ Watery eyes
- ○ Dry eyes
- ○ Painful/swollen eyes
- ○ Red eyes
- ○ Blurred vision
- ○ Floaters
- ○ Color blindness
- ○ Cataract
- ○ Double vision
- ○ Glaucoma
- ○ Ringing in ears
- ○ Hearing difficulties
- ○ Earaches
- ○ Ear infection

Nose and Sinuses
- ○ Frequent cold
- ○ Nose bleed
- ○ Runny nose
- ○ Stuffiness
- ○ Hay fever
- ○ Loss of smell
- ○ Sinus problems

Mouth and Throat
- ○ Sore throat
- ○ Excessive salivation
- ○ Teeth grinding
- ○ Sore tongue/lips
- ○ Gum problems
- ○ Hoarseness
- ○ Gagging/choking
- ○ Difficulty swallowing
- ○

Head and Neck
- ○ Headache/ migraine
- ○ Dizziness
- ○ Faintness
- ○ Vertigo
- ○ Jaw pain
- ○ Swollen glands
- ○ Goiter
- ○ Stiffness/ Pain
- ○ TMJ

Immune System
- ○ Chronic infections
- ○ Chronic fatigue Syndrome
- ○ Chronically swollen glands
- ○ Slow healing wounds

Cardiovascular
- ○ Heart disease
- ○ Angina/chest pain
- ○ Low/High blood pressure
- ○ Murmurs
- ○ Irregular heart beat
- ○ Palpitation/fluttering
- ○ Blood clots
- ○ Swelling of ankles

Circulation
- ○ Easy bruising
- ○ Excessive bleeding
- ○ Anemia
- ○ Deep leg vein
- ○ Varicose veins
- ○ Cold hands/feet
- ○

Skin
- ○ Rashes
- ○ Eczema/Hives
- ○ Acne/Boils
- ○ Itching
- ○ Fungal infections
- ○ Color/shape change
- ○ Hair loss
- ○ Dry Skin/scalp
- ○ Lumps
- ○ Night sweats
- ○ Slow healing ulceration
- ○ Hot Flashes

Respiratory
- ○ Chest congestion
- ○ Wheezing
- ○ Asthma
- ○ Bronchitis
- ○ Pneumonia
- ○ Emphysema
- ○ Shortness of breath
- ○ Difficulty breathing
- ○ Tuberculosis
- ○ Cough wet or dry
- ○ Coughing blood

Endocrine
- ○ Hypothyroid
- ○ Hyperthyroid
- ○ Heat or cold intolerance
- ○ Hypoglycemia
- ○ Diabetes
- ○ Excessive thirst
- ○ Excessive hunger
- ○ Fatigue
- ○ Seasonal depression

Muscle, Bones and Joints
- ○ Joint Pain
- ○ Muscle pain
- ○ Muscle spasm/cramps
- ○ Restless leg syndrome
- ○ Sciatica
- ○ Osteoporosis

Neurologic
- ○ Seizure
- ○ Paralysis
- ○ Muscle weakness
- ○ Numbness or tingling
- ○ Easily Stressed
- ○ Vertigo /dizziness
- ○ Loss of balance
- ○ Tics/Tremors
- ○ Easily startled

Digestion
- ○ Trouble swallowing
- ○ Heart burn/acid reflux
- ○ Change in thirst/appetite
- ○ Gastric ulcer
- ○ Nausea/Vomiting
- ○ Bloating or passing gas
- ○ Belching
- ○ Diarrhea
- ○ Constipation
- ○ Abdominal pain/cramps
- ○ Mucus in stool
- ○ Blood in stool
- ○ Hemorrhoids
- ○ Rectal pain
- ○ Itchy, Burning anus
- ○ Liver problem
- ○ Bowel Movement:
  How often? _____
  Stool:___hard, __ Firm
  ___ Soft, ___ Loose

Male Only
- ○ Hernia
- ○ Testicular pain/masses
- ○ Prostate disease
- ○ Sexual dysfunction
- ○ Sexually transmitted DZ
- ○ Discharge or sores

Urinary
- ○ Pain on urination
- ○ Increased frequency
- ○ Frequency at night
- ○ Urinary tract infections
- ○ Inability to hold urine
- ○ Kidney stones
- ○ Blood in urine
- ○ Heavy sensation
- ○ Retention of urine

Mental/Emotional
- ○ Mood swing
- ○ Anxiety/ nervousness
- ○ Depression
- ○ Suicidal thoughts
- ○ Poor concentration
- ○ Poor memory
- ○ Phobia

Female Only
- ○ Age menses began ___
- ○ Age of last menses ___
- ○ Length of cycle _____
- ○ Duration of flow_____
- ○ Date of last cycle ____
- ○ Birth control pills
  Type ?_____

Female Only
- ○ Painful Menses
- ○ Irregular cycle
- ○ Bleeding between cycles
- ○ Heavy or excessive flow
- ○ Passing clots
- ○ PMS
- ○ Pain during intercourse
- ○ Endometriosis
- ○ Uterine fibroids
- ○ Difficulty conceiving
- ○ Vaginal discharge
- ○ Vaginal odor
- ○ Ovarian cysts
- ○ Abnormal PAP
- ○ Breast pain/tenderness
- ○ Nipple discharge
- ○ Breast lumps
- ○ Menopause symptoms
- ○ Sexually transmitted Dz

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Please list any signs/symptoms or other health issues not listed above:

_____
_____
_____

I agree to the terms, I assert that, all the information herein is correct to the best of my knowledge. I authorize Golden Circle Acupuncture to communicate with my medical providers to coordinate care and provide me with the best treatment possible.

_____ Date _____
Patient Signature

_____ Date _____
Parent/ Guarantor Signature

Reviewed: _____ Date: _____