Seattle
Acupuncture and Coaching

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Confidential Patient Information

Today's Date:_____

Name:_____ Referred by:_____

Address: _____City_____ St:_____Zip:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Married Single Partner Divorced Widowed Date of Birth:_____ SS#_____
Email:_____ Occupation_____

Employer:_____ Supervisor's Name:_____

Emergency Contact:_____ Relation:_____
Home Phone:_____ Work Phone:_____

Primary Care Physician_____ Phone#_____
Have You Receive Acupuncture or Oriental Medicine Before? Yes No
Would You Like Us to Send You A Free Copy of Our Ebook on Chinese Medicine? Yes No

Insurance Information

Insurance Company:_____ Phone_____

Insured's Name:_____ Relation to Patient:_____

ID#_____ Group #_____Co-Pay_____ # Visits_____
Referral Yes No Covered %_____ Deductible_____

Auto Insurance Claim Info

Company_____ Claim #_____

Address_____

Phone_____ Adjuster_____

Attorney Information

Attorney Name:_____ Firm_____

Address_____Phone#_____

Primary Concern

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

When did it begin? _____

What makes it better? _____

What makes it worse? _____

What does this interfere with?

☐ Work	☐ Standing	☐ Sexually
☐ Sleep	☐ Emotional	☐ Recreation
☐ Walking	☐ Relationships	☐ Exercise
☐ Sitting	☐ Social Life	☐ Stretching

Body Pain

Do You Have Any Body Pain? Yes No Where?_____

Pain Intensity? Barely Any Moderate Severe

Have You Noticed Any Patterns with your pain? _____

What makes it better? _____

What makes it worse? _____

Medical History

Are you on any medication? Yes No If so, what types and how often? _____

Do you take Supplements? Yes No _____

Do you have any allergies? Yes No _____

List any past or future surgeries _____

_____

Female Concerns

Date of last menstruation _____ Is your cycle regular? Yes No Is your cycle painful? Yes No

Have you ever been pregnant? Yes No Birth Control? Yes No How Long? _____

Are you currently pregnant? Yes No If yes, Due Date:_____ OBGYN:_____

☐ PMS ☐ Clotting ☐ Vaginal Sores ☐ Vaginal Pain ☐ Discharge

Other

List any serious illness you have: _____

Are there any places you don't like touched? _____

Do you have a well balanced diet? Yes No Are you there any foods you don't eat? _____

Do you drink alcohol? Yes No Do you smoke? Yes No