



Seattle

Acupuncture and Coaching

3417 Evanston Ave N. #224, Seattle Wa 98103 301 775 6326 Fax 206 494 7443

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 # _____
Referral Yes No	Covered % _____
Deductible _____	Co-Pay _____ # Visits _____

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