

Los Altos Acupuncture Center

PATIENT RECORD & MEDICAL HISTORY

Last Name _____ First Name _____

Birthdate _____ Gender _____ Occupation _____

Home Address _____

City _____ State _____ Zip _____

Email _____

Cell Phone (_____) _____ Home Phone (_____) _____

How did you hear about us? _____ Referred by _____

Relationship status: Single Married Other

Emergency Contact _____ Phone (_____) _____

Do you plan on using health insurance? _____ **If yes, please fill out Insurance Verification Form**

Please check all of the boxes below that are now or have been a part of your personal health history.

	Current	Past		Current	Past		Current	Past
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Abortion	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menses	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Men's Health Issues	<input type="checkbox"/>	<input type="checkbox"/>
Angina (Chest Pain)	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal Injuries	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine Problems	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Urogenital Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	HIV, AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Women's Health Issues	<input type="checkbox"/>	<input type="checkbox"/>

If you have a family history of any of the above problems, please specify here:

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Please list all past surgeries and approximate dates:

Please list all medications you are currently taking:

Current Complaints: please describe your major health concerns & other relevant info not mentioned above:

Our Office Policy:

1. I authorize the release of any medical or other information necessary for insurance claim processing and I understand that my individually identifiable medical information will be used only as necessary for purposes of treatment, payment, and other healthcare operations.
2. If you are under 18 years of age, please have your parent or legal guardian sign below.
3. Los Altos Acupuncture Center is required by law, to maintain the privacy and confidentiality of your protected health information. The policy is available upon request.

I have read and agreed to the terms of the preceding paragraphs. All the information is true to the best of my knowledge.

Signature _____ Date _____