LOS ALTOS ACUPUNCTURE CENTER

PATIENT RECORD & MEDICAL HISTORY

First and Last Name_____

Birthdate_____Gender_____Occupations_____

Home Address_____

City_____State_____Zip Code_____

Email_____

Cell Phone (____)_____Home Phone (____)_____

How did you hear about us?_____Referred by_____

Relationship status: Single ☐ Married ☐ Other ☐

Emergency Contact_____Phone (____)

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

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

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

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

Please list all past surgeries and approximate dates

Please list all medications and supplements you are currently taking

Current Pain Status

Are you under the care of a physician?_____

Current pain level_____/10

Please describe your pain (How long have you had this pain, how often does this pain occur)

Stress Level (1=no stress, 10=high stress)_____

Sleep

What time do you typically go to sleep? _____What time do you typically wake up? _____

Is it difficult to stay asleep? Yes/No_____Do you wake feeling rested? Yes/No_____

Our Office Policy

1.I authorize the release of any medical or other information necessary for insurance claim processing and I understand that my individual identifiable medical information will be used only as a 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_____