Kalamazoo Acupuncture

JESSICA SILBER, MSTOM, DIPL.OM

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New Patient Information

Name ____ Today's Date
__________________ Street Address
____ Apt. _____________ City
_____________________________________ State _____________ Zip ______________
Preferred Phone ________________________ Email
_________________________________ Birth Date (include year) ___________________
Age ___________ Gender ____________ Occupation _____________________________
Employer ____________________________
Referred by
____
Emergency Contact: Name ________________________ Phone
____

Fees and Insurance:
It is Kalamazoo Acupuncture's policy that you pay the entire session fee at the time of each session. We will provide a minimum of one month's notice of any changes to our fees.

Kalamazoo Acupuncture does not bill insurance companies directly, at this time. However, we can provide you with a super bill after each treatment, which you can submit for reimbursement, from your insurance company.

Cancellation Policy:
If you need to change or cancel your appointment please do so with a minimum of 24 hours notice. Failure to do so will result in being charged the equivalent of the cash rate of the missed appointment to your account.

□ I understand the cancellation policy.

Signature:____________________________ Date: _____/_____/_____

(continued onto next pages)
Health History
Have you had acupuncture before? _________ If so, for what reason? __________________
Main issue(s) you are seeking treatment for: ____
____
____ Diagnosis from a medical professional (if applicable):
____
Please mark any areas of pain or discomfort:
Please check any symptoms that you have experienced in the past or currently experience:

General
past current past current

sweating easily during the day □ □ fatigue □ □
night sweating □ □ fevers □ □
bleed or bruise easily □ □ chills □ □
change in appetite □ □ weight loss/gain □ □
dizziness/vertigo □ □ poor sleep □ □

Skin & Hair
past current past current
rashes/hives □ □ psoriasis □ □
eczema □ □ loss of hair □ □
acne □ □

Head, Ears, Eyes, Nose & Throat
past current past current
earaches/pressure in the ears □ □ headaches/migraines □ □
ringing in the ears □ □ sinus pressure □ □
hearing loss □ □ nose bleeds □ □
eye floaters □ □ dizziness/vertigo □ □
itchy eyes □ □ teeth/jaw clenching □ □
blurry vision □ □

Cardiovascular/Circulatory
past current past current
chest pain □ □ swelling/edema □ □
fainting □ □ high blood pressure □ □
lightheadedness □ □ low blood pressure □ □
cold hands & feet □ □

Respiratory
past current past current
pain on inhaling □ □ sneezing □ □
chest tightness □ □ seasonal/other allergies □ □
cough □ □ phlegm production □ □
asthma □ □

Genito-Urinary
past current past current
difficulty urinating □ □ urgent/frequent urination □ □
blood in urine □ □ sores on genitals □ □
pain upon urination □ □ genital pain □ □

Neurological/Psychological
past current past current
anxiety □ □ poor memory □ □
depression □ □ quick temper □ □
loss of balance/coordination □ □ easily susceptible to stress □ □
areas of numbness/paralysis □ □

Digestive
past current past current
heartburn □ □ gas □ □
belching □ □ diarrhea □ □
bloating □ □ constipation □ □
nausea □ □ abdominal pain/cramps □ □
vomiting □ □ mucus in stool □ □
chronic bad breath □ □ blood in stool □ □
sores on lips/tongue □ □ hemorrhoids □ □

For Women Only:
past current past current
irregular periods □ □ breast pain □ □
painful periods □ □ vaginal discharge □ □
bleeding between periods □ □ vaginal sores □ □
period clots □ □ hot flashes □ □
menstrual cramping □ □ night sweating □ □
age of first menses _____________ duration of typical period ____________________
duration of typical cycle _______________ date of last PAP ______________________
# of pregnancies _____________________ # of live births (+ years) _______________
# of miscarriages _____________________ # of abortions ________________________
Have you been through menopause? Age?
____
Have you ever taken birth control pills? When and for how long? ________________________
Other premenstrual & menstrual symptoms (bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.)
____
_____
____
_____
____
_____

For Men Only:
past current past current
erectile dysfunction/impotence □ □ ejaculatory pain □ □
varicocele □ □ BPH □ □

Lifestyle
Current medications/herbs/supplements:
____
_____
____
_____
____
_____
Do you follow any certain diet or way of eating? (vegetarian, gluten-free, paleo, etc.)
____
_____
____
_____
____
_____

Current exercise routine:

____
____
____

Do you use tobacco? If so, how often?

____
____

Do you drink alcohol? If so, how many drinks/week?

____
____

Are you currently taking any of the following medications?
(circle if yes and indicate how often)
Advil/Motrin/Ibuprofen Aleve/Naproxen Bayer/Aspirin
Celebrex/Celecoxib Prednisone/Prednisolone

Are you currently taking any other pain medications? If yes, list name and amounts per day:

____
____
____

Allergies (medications/foods/chemicals/etc.):

____
____
____

Have you ever had a seizure? If yes, indicate date of last: ______________________
Please circle any significant illnesses and indicate date:
Cancer Hepatitis Diabetes
High blood pressure Epilepsy Heart Attack
Stroke Ulcer Disease Liver Disease
Colon Polyps Other ___________________

Please list any major surgeries/hospitalizations and approximate dates:

____
____
____
____

Family Medical History
□ Cancer □ Seizures □ High blood pressure □ Stroke □ Diabetes
□ Heart Attack □ Hepatitis □ Asthma □ Other ____________________

Please list any other relevant information or issues you would like to discuss:

Thank you for taking the time to fill out these forms. Please let me know if you have any questions or concerns.