acupuncture zen

New Patient Information

Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Is this a Cell Phone? (Please Circle) Yes No

Secondary Phone: _____ Is this a Cell Phone? (Please Circle) Yes No

Email: _____

Would you like to receive appointment reminders? (Please Circle) Yes No

What type of reminders? (Please Circle) Text Email Both

Text Reminders are sent 1 day before appt, Email reminders are sent 3 days before appt.

Birth Date: _____ Age: _____ Gender: Male Female

Height: _____ ft _____ in Weight: _____ lbs

Occupation: _____ Employer: _____

Emergency Contact-Name: _____ Phone: _____

Primary Care Physician-Name: _____ Phone: _____

Cancellation Policy

Acupuncture Zen respectfully requests a 24 hour notice if you are unable to make an appointment or need to reschedule. Repeated no shows without communication or repeated same-day cancellations will result in being asked to pre-pay in full for appointments. Failing to show up for prepaid appointments, or cancellations of less than 24 hours before prepaid appointment time will result in forfeiture of prepayment. To cancel or reschedule please call or text us directly. 419.438.0053. Do not directly reply to text reminders or email reminders, they come from an automated system and will not come back to the office.

***I have read and understand the cancellation policy_____**

(Patient Signature)

Health History:

Have you been treated with acupuncture before? YES NO How recently? _____

Please describe the issue(s) that brought you in today:

Problem/Illness/Pain:	How long has it been going on?
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____

Does anything make it better? _____

Does anything make it worse? _____

What else have you tried? (ex. chiropractic, physical therapy, massage, etc.)

How would you rate your stress level? (Please Circle) VERY HIGH HIGH MEDIUM LOW

Rate (on average) your activity level? (Please Circle) VERY ACTIVE ACTIVE RARELY ACTIVE

Do you smoke? YES NO If so, how long?_____ Packs per day?_____

Do you have any implanted devices? (ex. pacemaker, insulin pump, etc.)_____

_____

Please list any known Allergies: _____

_____

***If you have a current list of your medications or surgeries you can bring in a copy, or a copy can be made when you come in for your first visit.**

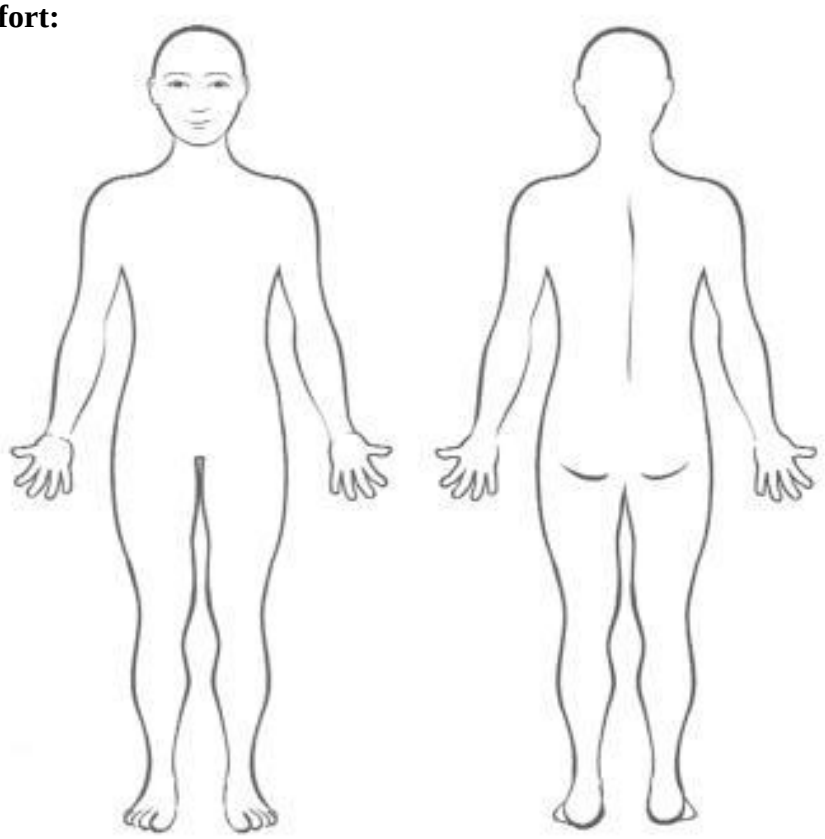
Please list all Medications/Supplements:	**Taken For:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list all Operations/Surgeries:	**Dates of Procedures**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please circle if you <u>have had</u> or <u>currently have</u> any of the following:

Depression/Anxiety	**Psychiatric Disorder**	**Substance/Drug Abuse**	**Insomnia**
Heart Attack/Heart Problems	**High/Low B. Pressure**	**Stroke**	**Anemia**
Tuberculosis	**Chronic Skin Infections**	**Hepatitis/Liver Disorders**	**HIV/AIDS**
Kidney Disorders	**Mononucleosis**	**Bleeding Disorders**	**Diabetes**
Seizures/Tremors	**Thyroid Problems**	**Cancer**	**Arthritis**
Dizziness/Fainting	**Vision Problems**	**Migraine Headaches**	**Fibromyalgia**
Hormone Disorders	**Chronic Sinus Issues**	**Jaw Pain/TMJ**	**Psoriasis**

Please mark any areas of pain or discomfort:



Is there anything that you would like to discuss that isn't covered on this form?

_____

_____

Patient Signature:_____ Date:_____