Oriental Medicine Associates

Affordable Alternative Health Care

Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This information will be confidential. If you have questions, please ask. Thank you!

Personal Information

Full Name: _____ Sex: F ☐ M ☐

Date of birth:_____Age:_____Occupation:_____

Main phone #:_____ Other phone #:_____

E-mail address:_____ Allow email contact by OMA? Yes ☐ No ☐
Allow Reminder Text Messages? Yes ☐ No ☐
Emergency contact & phone:_____

Address
Street:_____
City:_____ State: _____ Zip:_____
Family physician:_____

Do you have health insurance? Yes ☐ No ☐
If yes, name of insurance company?_____

Does your insurance cover acupuncture? Yes ☐ No ☐
Have you ever been treated by acupuncture before? Yes ☐ No ☐

How did you find out about our clinic?
Direct Mail ☐
Yellow Pages ☐
Periodicals ☐
Friends/Relatives:_____
Location or walk by ☐
Other (please specify):_____
Website/Referred by:_____

Medical Information

Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer	☐	☐	Breathing Problems	☐	☐
Diabetes	☐	☐	Heart Disease	☐	☐
Hepatitis	☐	☐	Digestive Orders	☐	☐
Thyroid Disease	☐	☐	Venerial Disease	☐	☐
Seizures	☐	☐	Alchoholism	☐	☐
Arthritis	☐	☐	Depression/Anxiety	☐	☐
Tuberculosis	☐	☐	Emotional Disorders	☐	☐
High Cholesterol	☐	☐	Anemia	☐	☐
High Blood Pressure	☐	☐	Other:_____	☐	☐

Surgeries/Hospitalization:_____

Significant trauma: (auto accidents, sports injuries, etc.) _____

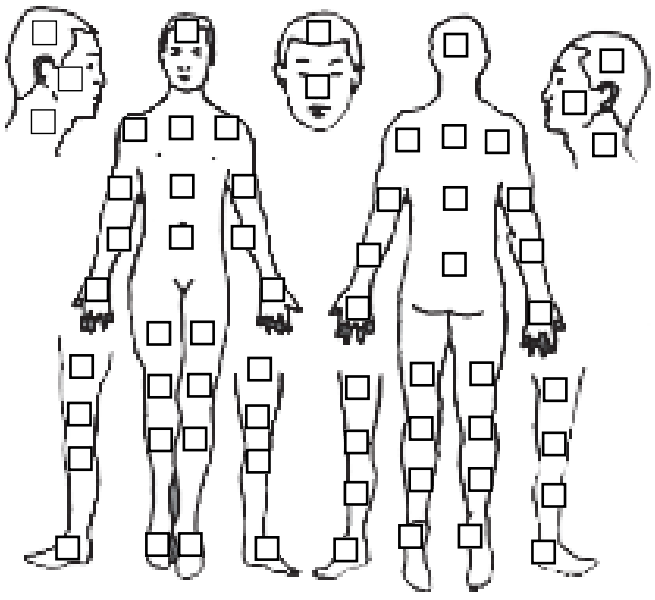
Allergies: _____

Medicines: _____

Medical Information

Describe the issue that brought you in today: _____
What diagnosis, if any, have you received for this problem?_____
When did this problem begin?_____
What are the causes of this problem?_____
To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)?_____
What kind of treatment have you tried?_____
What makes this problem worse?_____
What makes this problem better?_____
Is there anybody in your family with the same/similar problems?_____
Remarks and additional information:_____

Indicate painful or distressed areas by selecting the corresponding check box:



Make any additional notes here:

I have completed this form correctly to the best of my knowledge.

_____

Signature

_____

Adult Patient/Parent Or Guardian/Spouse

_____

Date

Please print and bring this form with you, or email to:
orientalmedicine@austin.rr.com
We look forward to seeing you!