ORIENTAL MEDICINE ASSOCIATES

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 INFO

Full name: **Sex:** F M **Date:**

Date of birth: **Age:** **Occupation:**

Main phone #: **Other phone #:**

E-mail address: _____ **Allow email contact by OMA?** Yes No

Emergency contact & phone: _____

Marital status: **# of children:**

Address
Street: _____
City: **State :** **Zip:**

Family physician: **Chiropractor:**

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? ***Friends/Relatives:*** _____
Direct Mail ***Location or walk by***
Yellow Pages ***Other (please specify):*** _____
Periodicals ***Website/Referred by:*** _____

MEDICAL HISTORY

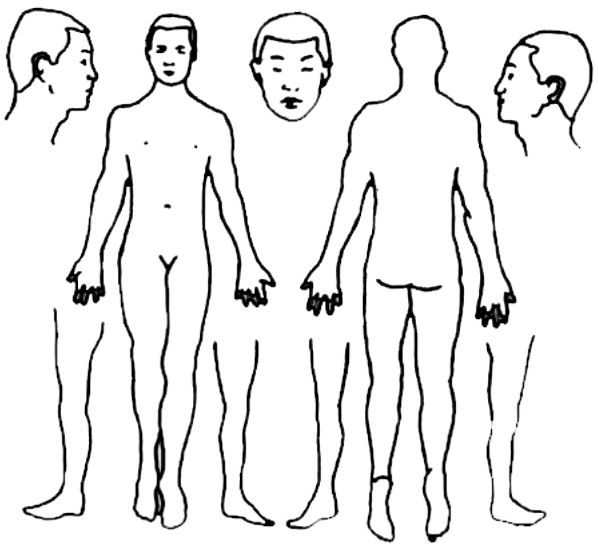
Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer			Breathing Problems		
Diabetes			Heart disease		
Hepatitis			Digestive disorders		
Thyroid disease			Veneral disease		
Seizures			Alcoholism		
Arthritis			Depression/Anxiety		
Tuberculosis			Emotional disorders		
High cholesterol			Anemia		
High blood pressure			Other:		

Surgeries/Hospitalization: _____
Significant trauma: ***(auto accidents, sports injuries, etc.)*** _____
Allergies: _____
Medicines: _____

MAIN PROBLEM

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 clicking on dots:



Make any additional notes here:

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

SIGNATURE: _____

Adult Patient
Parent or Guardian
Spouse

INSTRUCTIONS:

Print to fill out form.
Bring to office.

We look forward to seeing you!