

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. All your information will be confidential. If you have questions, please ask. Thank you.

Full name		Sex <input type="checkbox"/> F <input type="checkbox"/> M	Date
Date of birth	Age	Occupation	
Main phone #		Other phone #	
E-mail address		Allow email contact by OMA	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency contact name & phone		Marital status	# of children
Address: Street		City	State Zip
Family physician		Chiropractor	
Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of insurance company _____			
Does your insurance cover acupuncture? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ? Have you ever been treated by acupuncture before? _____			
How did you find out about our clinic? <input type="checkbox"/> Friends/Relatives(name) _____			
<input type="checkbox"/> Direct mail <input type="checkbox"/> Location or walk by <input type="checkbox"/> Website <input type="checkbox"/> Referred by _____			
<input type="checkbox"/> Yellow Pages <input type="checkbox"/> Periodicals <input type="checkbox"/> Other (please specify) _____			

Main problem(s): _____

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: _____

Medical History

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or anxiety			Other:		

Surgeries: _____ **Hospitalization:** _____

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

Allergies: (drugs, chemicals, foods, environmental): _____

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages): _____