



Capitol Hill Acupuncture

9-B Eighth Street, SE
Washington, DC 20003-1327
(202) 543-1911

ENTRANCE FORM

Name _____

Home Address _____

Phone _____ Cell Phone _____ E-mail _____

Occupation _____

Employer _____ Phone _____

Emergency Contact _____ Phone _____

Address _____

Referral Source _____

Purpose of Visit _____

Insurance Company _____ Policy No. _____

Primary Care Physician _____ Phone _____

I understand that I am financially responsible for all charges incurred. I agree to the 24-hour cancellation policy – a \$50.00 fee is charged when an appointment is cancelled less than 24 hours before the scheduled appointment time. I agree to turn off my cell phone during treatment.

Signature _____ Date _____

(Confidential)

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- Chills, Depression, Dizziness, Fainting, Fever, Forgetfulness, Headache, Loss of sleep, Loss of weight, Nervousness, Numbness, Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- Arms, Back, Feet, Hands, Hips, Legs, Neck, Shoulders

GENITO-URINARY

- Blood in urine, Frequent urination, Lack of bladder control, Painful urination

GASTROINTESTINAL

- Appetite poor, Bloating, Bowel changes, Constipation, Diarrhea, Excessive hunger, Excessive thirst, Gas, Hemorrhoids, Indigestion, Nausea, Rectal bleeding, Stomach pain, Vomiting, Vomiting blood

CARIOVASCULAR

- Chest pain, High blood pressure, Irregular heart beat, Low blood pressure, Poor circulation, Rapid heart beat, Swelling of ankles, Varicose veins

EYE, EAR, NOSE, THROAT

- Bleeding gums, Blurred vision, Crossed eyes, Difficulty swallowing, Double vision, Earache, Ear discharge, Hay fever, Hoarseness, Loss of hearing, Nosebleeds, Persistent cough, Ringing in ears, Sinus problems, Vision - flashes, Vision - halos

SKIN

- Bruise easily, Hives, Itching, Change in moles, Rash, Scars, Sore than won't heal

MEN ONLY

- Breast lump, Erection difficulties, Lump in testicles, Penis discharge, Sore on penis, Other

WOMEN ONLY

- Abnormal Pap Smear, Bleeding between periods, Breast lump, Extreme menstrual pain, Hot flashes, Nipple discharge, Painful intercourse, Vaginal discharge, Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Conditions

Check (✓) conditions you currently have or have had in the past year.

- AIDS, Alcoholism, Anemia, Anorexia, Appendicitis, Arthritis, Asthma, Bleeding disorders, Breast lump, Bronchitis, Bulimia, Cancer, Cataracts, Chemical Dependency, Chicken Pox, Diabetes, Emphysema, Epilepsy, Glaucoma, Goiter, Gonorrhea, Gout, Heart Disease, Hepatitis, Hernia, Herpes, High Cholesterol, HIV Positive, Kidney Disease, Liver Disease, Measles, Migraine Headaches, Miscarriage, Mononucleosis, Multiple Sclerosis, Mumps, Pacemaker, Pneumonia, Polio, Prostate Problem, Psychiatric Care, Rheumatic Fever, Scarlet Fever, Stroke, Suicide Attempt, Thyroid Problems, Tonsilitis, Tuberculosis, Typhoid Fever, Ulcers, Vaginal Infections, Venereal Disease

Medications

List medications you are currently taking.

Allergies

Pharmacy Name _____ Phone _____

HEALTH HISTORY

Family History

Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your blood relatives had any of the following: Disease Relationship to you	
Father					<input type="checkbox"/> Arthritis/Gout	
Mother					<input type="checkbox"/> Asthma, Hay Fever	
Brothers					<input type="checkbox"/> Cancer	
					<input type="checkbox"/> Chemical Dependency	
					<input type="checkbox"/> Diabetes	
					<input type="checkbox"/> Heart Disease/-strokes	
Sisters					<input type="checkbox"/> High Blood Pressure	
					<input type="checkbox"/> Kidney Disease	
					<input type="checkbox"/> Tuberculosis	
					<input type="checkbox"/> Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which substances you use and describe how much you use.

<input type="checkbox"/> Caffeine	
<input type="checkbox"/> Tobacco	
<input type="checkbox"/> Drugs	
<input type="checkbox"/> Other	

Have you ever had a blood transfusion? Yes No

If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

Occupational

Check (✓) if your work exposes you to the following:

<input type="checkbox"/> Stress	<input type="checkbox"/> Hazardous Substances
<input type="checkbox"/> Heavy Lifting	<input type="checkbox"/> Other

Occupation _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____

Date _____

Reviewed By _____

Date _____