FIRE HORSE ACUPUNCTURE

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Legal name: ____

Preferred name (if different):______________________________________

Birth date:____________________ Sex/Gender: M F FTM MTF I ______________________

Address:____

____

Phone: ____ May we contact you by phone? Y N

Email address:____________________________________ May we contact you by email? Y N

Emergency contact: ____

Phone number for emergency contact:___________________________________

Are you: Married Single Partnered Divorced Other:__________________

Insurance Information

Will we be billing insurance for you? Y N If yes, please have your card ready to give us.

Fill out the following if you've had a work or auto accident:

Have you been in an auto or work accident? auto accident work accident

If so: Who is your auto insurance carrier?______________________ ID #_________________

Group#______________________________ Plan:___________________________________

Insurance company address: ____

Submit to (claim adjuster): ____

Relationship to insured: Self Spouse Child Other

If not self, insured's name:____

Insured's address: ____

Insured's phone: _________________________________ Insured's legal gender: F M

Personal Health History

Please circle for CURRENT issues, and underline for PAST issues

Please star* those that you have been diagnosed with, but are not confident in the diagnosis.

Do you have a history of diagnosis with any of the following illnesses?

<u>Cardiac (Heart)</u>

High Blood Pressure (Hypertension)
Heart Attack
Stroke
Angina
Congestive Heart Failure
Mitral Valve Prolapse
Mitral Stenosis
Atherosclerosis
Other:
____
____

<u>Hepatic (Liver)</u>

Cirrhosis
Hepatitis A
Hepatitis B/C
Other Hepatitis
Alcoholism
Fatty Liver Disease
Gallstones/Sludge
Other:
____
____
____

<u>Respiratory (Lung)</u>

Allergies
Sinus Congestion
Sinusitis
Cough
Lung Collapse
Lung Enlargement
Ascites
COPD
Other:
____
____
____

<u>Skin/Hair</u>

Acne
Dryness
Eczema
Psoriasis
Dermatitis
Rash
Hives
Tinnea
Athlete's Foot
Alopecia
Other:
____

<u>Digestive</u>

Heartburn
Loose stool
Constipation
IBS
Ulcerative Colitis
Crohn's Disease
Blood in stool
Other:
____
____
____

<u>Mental/Emotional</u>

Anxiety
Depression
Insomnia
PTSD
OCD
Addiction
Bipolar
Schizophrenia
Other:
____
____
____
____

<u>Immune/Autoimmune</u>

Multiple Sclerosis
Grave's Disease
Lupus
Rheumatoid Arthritis
Addison's Disease
Cancer
Childhood Onset Diabetes
Adult Onset Diabetes
Hashimoto's Thyroiditis
Meniere's Disease
Narcolepsy
Reynaud's
HIV/AIDS
Other:
____
____
____
____
____

Renal (Kidney)

UTI
Bladder or Kidney Infection
Daytime Frequent Urination
Nighttime Frequent Urination
Kidney Stones
Cystic Kidney Disease
Blood in Urine
Interstitial Cystitis
Other:

Eyes

Blurry Vision
Floaters
Near-sightedness
Far-sightedness
Cataracts
Glaucoma
Macular Degeneration
Other:

Reproductive System

Male Born:

Erectile Dysfunction
Balanitis
Prostatitis
Prostate Cancer
Testicular Inflammation
Other:

Ears

Ear Infection
Hearing Loss
Deafness (full or partial)
Tinnitus
Other:

Head

Headache
Migraines
Dizziness
Other:

Reproductive System

Female Born:

Breast tenderness or swelling
Fibrocystic breast tissue
PMS
Menstrual cramping
Endometriosis
Ovarian Cysts
Polycystic Ovarian Syndrome (PCOS)
Uterine Fibroids
Menopausal Syndrome
Vaginal Atrophy
Other:

Throat

Tonsillitus
Tonsil Stones
Dryness
Post Nasal Drip
Hoarseness
Other:

Please list all allergies:

Please list all hospitalizations & surgeries:

What health concerns have brought you here? ____

____

____

What do you normally eat?

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Beverages: ____

Cravings:____

What is your occupation?____________________________ Do you enjoy your work?________

What sort of exercise do you do?____

Do you have a religious or spiritual ritual? ____

What are your hobbies & interests?____

What else would you like us to know? ____

____

Familial Health History

Maternal health history (cancer, diabetes, stroke, etc):_________________________

____

Paternal health history: ____

____

Sibling health history:____

____

Spouse, partner health history (infectious disease, cancer, etc):____________________________

____

Do you have biological children?   Y   N   If yes, how many?_____________________________

Is there anything else about your family, that may be relevant to your health that you think we

should know?:____

____

____

____

____

Please note that none of your, or your family's health history will be shared unless in the case of immediate physical harm present to you or your family (child abuse, geriatric abuse, assault, etc).

Thank you! We will talk more during our appointment!