New Patient Information
Amy S.B. Taylor Mitchell, M.S., L.Ac.

Patient Information

Patient's Name________________________________Today's Date__________
Street Address________________________________Apt. # ______________
City____ State ______Zip _______
Home Phone (______)___________________________Office (_____)_________
Other Phone (______)___________________________Email ______________
Birth Date_________________ Age _______________Gender______________

__ single __ married __ divorced __ widowed __ domestic partnership __ other ________

Referred by____

Emergency Contact __________________________Relationship______________
Emergency Contact Phone # home (______)__________Office or Cell____________
Physician's Name___________________________Phone___________________
Date of last visit ___________________________

Employment - Please check all that apply
__ full-time __ part-time __ self-employed __ student __ unemployed __ retired

Occupation_________________________ Number of hours of work/study per week____

Employer's Name______________________________Phone (______)________

Billing and Insurance

Note on Insurance
Payment in full is due at the time services are rendered. $85 per visit plus $65 for new patient. Upon request a Superbill will be provided. A Superbill is a receipt that you may submit directly to your insurance company to seek reimbursement for payments made. You may call your insurance company to inquire if acupuncture services are covered under your policy.

Primary Insurance__________________________Phone (______)__________
Primary Insurance Address____
Policy Holder's Name_______________________Relationship ______________
Policy # / ID # ___________________________Group #__________________

Superbill requests __ No, thanks! __ Once a month __ At the end of each treatment

Missed Appointment Policy
If you need to change or cancel your appointment please do so with 24 hours notice. Failure to do so will result in being charged $85.

__ I understand cancellation policy.

Amy S. B. Taylor Mitchell, M.S. L.Ac.

Confidentiality

Your patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by your authorization, or when required or permitted by law.

Health History

Patient Name____ Date ____________________

Have you had acupuncture treatment before? If so, for what reason?______________________

____

Pain

l, r, b = left, right, or both sides

past	current		past	current		past	current		past	current	
__	__	head	__	__	forearm l r b	__	__	upper back	__	__	shin l r b
__	__	jaw	__	__	wrist l r b	__	__	mid-back	__	__	ankle l r b
__	__	neck	__	__	hand l r b	__	__	low back	__	__	foot l r b
__	__	throat	__	__	fingers l r b	__	__	hip l r b	__	__	heel l r b
__	__	shoulder l r b	__	__	chest	__	__	thigh l r b	__	__	toes l r b
__	__	upper arm l r b	__	__	rib / flank	__	__	knee l r b			
__	__	elbow l r b	__	__	abdomen	__	__	calf l r b			

other current related symptoms____

ST

past	current	
__	__	nausea / vomiting
__	__	belching
__	__	heartburn
__	__	bad breath
__	__	bleeding gums
__	__	ulcers
__	__	excessive appetite
__	__	change in appetite
__	__	nose bleeds
__	__	difficulty swallowing
__	__	recurring sore throat
__	__	laryngitis / hoarse voice

Sp

past	current		past	current	
__	__	gas	__	__	diarrhea
__	__	abdominal bloating	__	__	constipation
__	__	abdominal pain	__	__	blood in stools / black
__	__	decreased appetite	__	__	pus in stools
__	__	indigestion	__	__	hemorrhoids
__	__	low energy / fatigue	__	__	anal fissures
__	__	crave sweets	__	__	rectal pain
__	__	decreased sense of taste / smell			
__	__	sweet taste in mouth			
__	__	often feel pensive / thoughtful			
__	__	edema			

other current related symptoms____

AMY S. B. TAYLOR MITCHELL, M.S. L.AC.

Lu

past current
__ __ frequent colds
__ __ sinus infection
__ __ cough
__ __ cough with blood
__ __ production of phlegm
__ __ hay fever or allergies

past current
__ __ asthma
__ __ bronchitis
__ __ pneumonia
__ __ COPD

past current
__ __ often feel sad
__ __ crave pungent foods
__ __ dry skin
__ __ itching
__ __ acne
__ __ rashes, hives, eczema or psoriasis

other current related symptoms____

K

past current
__ __ frequent urination
__ __ urgency to urinate
__ __ pain on urination
__ __ urine/bowel incontinence
__ __ weak urine stream
__ __ blood in urine
__ __ kidney stones
__ __ low back pain
__ __ sore / weak knees
__ __ crave salty foods
__ __ often feel afraid

past current
__ __ frequent urinary tract infections
__ __ frequent vaginal infections
__ __ pelvic inflammatory disease
__ __ abnormal PAP smear
__ __ irregular periods
__ __ premenstrual syndrome
__ __ painful menstrual periods
__ __ abnormal bleeding
__ __ menopause symptoms
__ __ breast lumps

past current
__ __ impotence
__ __ premature ejaculation
__ __ testicular lumps
__ __ prostatitis
__ __ genital itching / pain
__ __ genital lesions/ discharge
__ __ decreased libido
__ __ ear ringing – low pitch
__ __ ear ringing – high pitch
__ __ decreased hearing
__ __ ear infections

Total Pregnancies____________Living________Ectopic_____________Miscarriages__________
Induced Abortions______________________

other current related symptoms ____

Lv.

past current)
__ __ dry eyes
__ __ red eyes
__ __ eye inflammation
__ __ blurred vision
__ __ poor night vision
__ __ floaters (spots in the visual field)

__ __ visual changes
__ __ glasses / contact lenses
__ __ cataracts
__ __ crave sour foods

X

past current
__ __ insomnia
__ __ excessive / vivid dreams
__ __ grinding teeth
__ __ depression
__ __ anxiety / stress
__ __ irritability

__ __ treated for emotional / psychological problems
__ __ indecisiveness
__ __ often feel angry

past current
__ __ migraine
__ __ dizziness
__ __ fainting
__ __ seizures
__ __ localized weakness
__ __ numbness or tingling of limbs
__ __ tremors
__ __ poor concentration
__ __ paralysis
__ __ aversion to wind
__ __ tendinitis
__ __ gallstones

other current related symptoms ____

Ht

past current
__ __ high blood pressure
__ __ low blood pressure
__ __ palpitations
__ __ irregular heart beat

past current
__ __ chest pain or pressure
__ __ jaw, neck, shoulder or arm pain
__ __ nausea
__ __ swollen hands or feet

past current
__ __ blood clotting disorders
__ __ phlebitis
__ __ poor memory
__ __ crave bitter foods

other current related symptoms ____

YM

past current
__ __ fevers
__ __ frequent or strong thirst
__ __ tend to feel warmer than others
__ __ night sweats
__ __ sweat easily
__ __ prefer cold food and drink

past current
__ __ chills
__ __ hands / feet
__ __ tend to feel colder than others
__ __ cold sweats
__ __ prefer warm food and drink

past current
__ __ headache
__ __ neck stiffness
__ __ concussion
__ __ enlarged lymph

tumors or lumps ____
____
____

past current
__ __ HIV
__ __ TB
__ __ chicken pox
__ __ meningitis
__ __ hepatitis

past current
__ __ gonorrhea
__ __ chlamydia
__ __ syphilis
__ __ genital warts
__ __ herpes oral / genital

past current
__ __ SARS
__ __ west nile

other past or current infectious diseases ____
____

recent tests and indicate results
cholesterol__________________blood pressure__________________mammography_______________
prostate____________________blood work_____________________STD Check_________________
other tests and results____
____

FAMILY HISTORY Complete for each family member, placing an X in the appropriate box

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood Disorder / Anemia							
Diabetes							
Cancer or Tumors							
Seizures							
High Blood Pressure							
Kidney or Bladder Disorder							
Stomach or Intestinal Disorder							
Drug / Alcohol Use or Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression / Mental Illness							
Suicide Attempt							
Age at Death							

Major Hospitalizations – Please list any hospitalization or surgeries you have undergone

Year Operation or Illness Name of Hospital City and State
____
____
____
____

Medicines, Herbs, Supplements – Please check any that you are currently taking

__ aspirin
__ ibuprofen
__ acetaminophen (Tylenol)
__ oral contraceptives
__ antacids
__ fiber / laxatives
__ diet pills
__ allergy medication
__ blood thinners
__ blood pressure pills
__ insulin
__ antidepressants
__ sleeping pills
__ tranquilizers

other, please list ____
____
____

AMY S. B. TAYLOR MITCHELL, M.S. L.AC.

Western Drugs		Herbs		Vitamins and Supplements

____
____
____

Medication Allergies____

Food Allergies____

Habits – Please check any habits which apply to you now or in the past

Habit	yes / no	# per day	age started	age quit
Coffee	__ yes __ no	# per day______	age started______	age quit______
Tobacco	__ yes __ no	# per day______	age started______	age quit______
Marijuana	__ yes __ no	# per day______	age started______	age quit______
Alcohol	__ yes __ no	# per day______	age started______	age quit______
Crack/Cocaine	__ yes __ no	# per day______	age started______	age quit______
Heroin	__ yes __ no	# per day______	age started______	age quit______

Please describe any restricted diet you follow(ed) now or in the past______________________
____

Please describe you typical daily diet

Breakfast______________________________ Morning Snack______________

Lunch________________________________ Afternoon Snack______________

Dinner_______________________________ Evening Snack______________

Please list your health concerns in order of importance –

Please describe any regular program of exercise -

Do you have a religious or spiritual practice? If so, please describe -

What are the top priorities in your life?

What are your goals for your health?

Please provide any additional information about yourself or your condition not covered by the above questions.