Welcome

Thank you for selecting our healthcare team! We will strive to provide you with the best possible health care. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

1. Personal Information

Date:_____

Birthdate;_____ Name:_____

Wishes to be called:_____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address:_____

City:_____ State:_____ Zip/PC: _____

E-mail:_____

Employer:_____ Occupation:_____

Referred by:_____

2. Responsible Party

Who is responsible for the account?

Name:_____

Relationship to patient:_____ Birthdate:_____

Address:_____

City:_____ State:_____ Zip/PC: _____

E-mail:_____

Employer:_____ Occupation:_____

Work Phone: _____ Ext#:_____

Home Phone:_____ Cell Phone:_____

3. Telephone

Employer:_____ Occupation:_____

Work Phone: _____ Ext#:_____

Home Phone:_____ Cell Phone:_____

Where do you prefer to receive calls: ☐ Home ☐ Work ☐ Cell

When is the best time to reach you? ☐ Time ☐ Days

In the event of an emergency, who should we contact?

Name_____ Relationship_____ Work#_____ Home#_____

4. Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services, I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ _____

Signature of patient or parent/guardian if minor Date

5. Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment in full at each appointment _____Cash _____Personal Check _____Credit Card:_____Visa _____MC _____I wish to discuss the office's payment policy.	**Late Charges** If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1/5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this account or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask – we are always happy to help.

Patent Consent, Waiver & Release

Acupuncture is a form of treatment that has been in existence for at least three thousand years. It's part of a holistic system of medicine that takes a person's body, emotions, activities, diet and environment into consideration.

Acupuncture works on the body's life force, a quality no yet measurable by machines. The Chinese word for this force is "qi", pronounced "chee". Think of it as the body's electrical system. Most of our muscles function because of electrical charges that flow throughout our cells, or along certain pathways called meridians.

A reduction, increase, or blockage of that flow of energy may result in pain, dysfunction and or/disease. Acupuncture does not cure, or even treat "diseases". Rather, it strives to balance that energetic flow, which allows the body to heal itself.

Occasionally, a patient will experience some side-effects, such as bruising or soreness (at the needle site), light-headedness, fatigue, and/or temporary increase in pain. These effects never last long. Often this is a sign the treatment is working. However, be sure to advise your practitioner if you experience any such effects.

Acupuncture treatment is often accompanied by recommendations for herbal treatment, or dietary changes, or exercises, which are intended to enhance the ability of the body to heal itself.

Herbal treatment can be recommended either alone or as a companion treatment with traditional Western medicine. Such herbal treatment may affect patients differently; depending upon the length, severity, type, treatment of, and other medication prescribed for, their illness.

As part of consideration of the efforts made to alleviate pain, increase energy and improve my physical condition; I, the undersigned, consent to treatment, waive and release any and all rights and claims for damages I may have against William Christopher Powell, aka Chris Powell, Missouri Acupuncture Services, and their representatives, volunteers, employees, successors and assigns, or any of them, for Any and all injuries and/or losses suffered by me through treatment or as a result of treatment.

Date: _____ Signature:_____

Medical History Form

Name _____ Age _____ Single Married Divorced Widow(er) Date _____

Occupation _____ All Previous Occupations _____

Birth Place _____ Birthdate _____ List all States in which you have lived _____

Education: _____ years High School _____ years College _____ years Post Grad

Date of last physical examination _____

Please list all Symptoms

1. _____
2. _____
3. _____
4. _____
5. _____

Routine Check-up - No Symptoms ☐

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so or by court order.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

PATIENT SIGNATURE _____

PHYSICIAN'S REVIEW SIGNATURE _____

	If Living Age	Health	If Deceased Age at death	Cause	Has any blood relative ever had:	Please encircle No or Yes		Who
Father					Cancer	No	Yes	
Mother					Tuberculosis	No	Yes	
Brother or Sister 1.					Diabetes	No	Yes	
2.					Heart Trouble	No	Yes	
3.					High Blood Pressure	No	Yes	
4.					Stroke	No	Yes	
Husband or Wife					Epilepsy	No	Yes	
Son or Daughter 1.					Insanity	No	Yes	
2.					Suicide	No	Yes	
3.								
4.								

PERSONAL HISTORY

ILLNESSES: Have you ever had

PLEASE ENCIRCLE ALL ANSWERS	No	Yes
Measles	No	Yes
German Measles	No	Yes
Mumps	No	Yes
Chicken Pox	No	Yes
Whooping Cough	No	Yes
Scarlet fever or Scarlatina	No	Yes
Diphtheria	No	Yes
Smallpox	No	Yes
Pneumonia	No	Yes
Influenza	No	Yes
Pleurisy	No	Yes
Rheumatic Fever or Heart Disease	No	Yes
Arthritis or Rheumatism	No	Yes
Any bone or joint disease	No	Yes
Neuritis or Neuralgia	No	Yes
Bursitis, Sciatica or Lumbago	No	Yes
Polio or Meningitis	No	Yes
Nephritis	No	Yes
Gonorrhea or Syphilis	No	Yes
Gallbladder disease	No	Yes
Anemia	No	Yes
Jaundice	No	Yes
Bladder disease	No	Yes
Epilepsy	No	Yes
Migraine headaches	No	Yes
Tuberculosis	No	Yes
Diabetes	No	Yes
Cancer	No	Yes
High or low blood pressure	No	Yes
Colitis or other bowel disease	No	Yes
Hemorrhoids or any rectal disease	No	Yes
Nervous Breakdown	No	Yes
Food, chemical or drug poisoning	No	Yes
Hay fever or Asthma	No	Yes
Hives or Eczema	No	Yes
Frequent infections or boils	No	Yes
AIDS	No	Yes
Any other disease	No	Yes

ALLERGIES: Are you allergic to

Penicillin or Sulfa	No	Yes
Aspirin, Codeine or Morphine	No	Yes
Mycins or other Antibiotics	No	Yes
Merthiolate or Mercurochrome	No	Yes
Any other drug	No	Yes
Any foods	No	Yes
Adhesive Tape	No	Yes
Nail polish or other cosmetics	No	Yes
Tetanus Antitoxin or Serums	No	Yes

INJURIES: Have you had any

Broken or cracked bones	No	Yes
Sprains	No	Yes
Lacerations	No	Yes
Dislocations	No	Yes
Concussion, or head injury	No	Yes
Ever been knocked unconscious	No	Yes

WEIGHT: Now _____ One Year Ago _____

Maximum _____ When _____

TRANSFUSIONS: Have you ever had

Blood or Plasma Transfusion	No	Yes

SURGERY: Have you had

Tonsillectomy	No	Yes
Appendectomy	No	Yes
Any other operation	No	Yes

Type _____ Year _____

Type _____ Year _____

Type _____ Year _____

Do you smoke No Yes

How many per day _____

Have you ever been advised to have any surgical operation which has not been done _____ No Yes

Have you been hospitalized for any illness _____ No Yes

Give details:

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

Frequent or severe headaches No Yes
Fainting spells No Yes
Dizziness on change of position No Yes
Unconscious Spells No Yes
Blurred Vision No Yes
Double Vision No Yes
Spots before eyes No Yes
Infected eyes No Yes
Pain behind eyes No Yes
Any change in vision No Yes
Do you wear glasses No Yes
When were they last checked
Earaches No Yes
Discharge from Ears No Yes
Ringing in ears No Yes
Decrease in hearing No Yes
Recurrent nose bleeds No Yes
Recurrent head colds No Yes
Sinus Trouble No Yes
Hay fever No Yes
Strange persistent odors No Yes
Strange taste or loss in taste No Yes
Persistent hoarseness No Yes
Difficulty swallowing No Yes
Enlarged glands No Yes
Recurrent sore throats No Yes
Recurrent sores in mouth No Yes
Soreness or bleeding of gums on brushing No Yes
Chest pain No Yes
Angina pectoris No Yes
Coughed up blood No Yes
Pain in arm(s) No Yes
Night sweats No Yes
Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) No Yes
Chronic or frequent cough on lying down No Yes
Wake up at night short of breath No Yes
How many bed pillows do you use _____
Shortness of breath on:
Walking several blocks No Yes
One flight of stairs No Yes
On lying down No Yes
Purple lips or fingers No Yes
Palpitations or fluttering of heart No Yes
High blood pressure No Yes
Swelling of hands, feet or ankles No Yes
At what time of day
Leg cramps on walking or at night No Yes
Enlarged veins in legs No Yes
Recurrent stomach pain No Yes
Belching or heartburn No Yes
Relieved by food or medication No Yes
Appetite - Good ☐ Fair ☐ Poor ☐
Nausea or vomiting No Yes
Vomited blood No Yes
Avoid some foods No Yes
What kinds
Avoid spices No Yes
Abdominal cramping No Yes
Color of bowel movement
Any blood in BM No Yes
Rectal pain with bowel movement No Yes

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

Change in size, shape or texture of BM No Yes
Describe
Pain on urinating No Yes
Difficulty in starting urination No Yes
Do you get up at night to urinate No Yes
How many times
Urinate more than before No Yes
Urinate less than before No Yes
Any blood in urine No Yes
How many times per day do you urinate
Full feeling of bladder, but only small amount of urination No Yes
Lose urine on coughing or sneezing No Yes
Discharge from penis No Yes
Recurrent back pains No Yes
Backaches No Yes
Joint pains No Yes
Swelling of any joints No Yes
Redness or heat of any joint No Yes
Tingling or weakness of hands or feet No Yes
Muscle Spasms No Yes
Loss or change in sensation of hands or feet No Yes
Trembling of any extremity No Yes
Growth in neck or throat No Yes
Hot flashes No Yes
Tiredness without apparent reason No Yes
Brittleness of nails No Yes
Dryness of skin No Yes
Easy bruising No Yes
Inability to stand heat No Yes
Inability to stand cold No Yes
Change in hair texture No Yes
Change in skin texture No Yes
Any skin rash No Yes

X-RAYS: Have you ever had x-rays of
Chest No Yes
Stomach or colon No Yes
Gall bladder No Yes
Extremities No Yes
Back No Yes
Teeth No Yes
Other No Yes

EKG: Ever had an electrocardiogram? No Yes

IMMUNIZATIONS: Have you had
Smallpox vaccination within last 7 years No Yes
Tetanus shots (not antitoxin which lasts only 2 weeks) No Yes
Polio shots within last 2 years No Yes

DRUGS: Laxatives; never ☐ occ. ☐ freq. ☐ daily ☐
Vitamins; never ☐ occ. ☐ freq. ☐ daily ☐
Sedatives; never ☐ occ. ☐ freq. ☐ daily ☐
Tranquilizers; never ☐ occ. ☐ freq. ☐ daily ☐
Sleeping pills, etc.; never ☐ occ. ☐ freq. ☐ daily ☐
Aspirin, etc.; never ☐ occ. ☐ freq. ☐ daily ☐
Cortisone, ACTH; never ☐ occ. ☐ freq. ☐ daily ☐
Thyroid; never ☐ yes, in past, none now ☐
daily ☐ now on _____ gr. day
Appetite depressants never ☐ occ. ☐ freq. ☐ daily ☐

Have you ever been treated for drug habits No Yes
Have you ever taken insulin or tablets for diabetes No Yes
Have you ever taken hormone tablets or injections No Yes
Have you ever taken Fen-Phen/Redux No Yes
SEX: Entirely satisfactory? No Yes

WOMEN ONLY - MENSTRUAL HISTORY

Age at onset
Regular? ☐ Yes ☐ No ☐ Varies
Cycle _____ days (from start to finish)
Flow: Heavy ☐ Medium ☐ Light ☐
Number of pads used per period
Any clots passed No Yes
Pains or cramps No Yes
Date of last period
Date of last pelvic exam
Date of last Pap Test
Results: ☐ Neg. ☐ Pos.
Any discharge from vagina No Yes
If so, color
amount
Any itching of vaginal area No Yes
Do you take birth control pills No Yes
How long have you taken them
Pregnancies:
How many children born alive
How many still births
How many premature births
How many Cesarean Sections
How many miscarriages
Any complications with pregnancy No Yes
Describe
Other