ACUPUNCTURE NEW PATIENT

Patient Name: _____ DOB: _____ M / F / O

Address: _____ Marital Status: S / M / D / W / O

_____

Cell Phone: _____ Email: _____

Home Phone: _____ Work Phone: _____

Emergency Contact Name & Number: _____

Referred by: _____ Occupation: _____

Current MD or DO: _____ Telephone: _____

Current Medical Conditions you are being treated for: _____

List all current medications, supplements, eye drops, over the counter, topical and dosage information:

Medication	Dosage	Reason for taking	Medication	Dosage	Reason for taking

Do you take coumadin, heparin or warfarin or any blood thinners: YES / NO

Present problem that brings you here today: _____

_____

Do you have any pain: YES / NO

Please describe how it feels to you:_____

How has it impacted your life: _____

How is your energy: _____

How do you feel emotionally: _____

Describe your dieting/eating habits. How many servings of:

Meat/Fish/Fowl	_____ / day or week	Flour products	_____ / day or week
Vegetables	_____ / day or week	Sugar/Sweets	_____ / day or week
Fruits	_____ / day or week	Water	_____ / day or week
Dairy	_____ / day or week	Tea/Coffee	_____ / day or week
Whole grains	_____ / day or week	Soda	_____ / day or week

List all allergies: _____

Do you smoke: Cigarettes / VAPE / Marijuana YES / NO How many per day: _____ How many years: _____

Do you drink alcohol: YES / NO How many per day/week/month: _____

Do you have a pacemaker or any other implantable medical devices: YES / NO Type: _____

Nightly sleep: _____ hours Sleep difficulties: YES / NO Explain: _____

Do you exercise: YES / NO Describe:_____

Anything significant about your birth: _____

Family history (cancer, diabetes, high blood pressure, heart disease, stroke, allergy, asthma, alcoholism, TB, etc.)

Maternal Grandmother: _____ Maternal Grandfather: _____

Mother: _____

Paternal Grandmother: _____Maternal Grandfather: _____

Father: _____

Siblings: _____

Your Children: _____

Where do you hold your tension: _____

Past medical history:

Measles (Vaccine):	Y / N	Mumps (Vaccine):	Y / N	Chicken Pox (Vaccine):	Y / N
Whooping Cough:	Y / N	Scarlet Fever:	Y / N	Diphtheria:	Y / N
Rheumatic Fever:	Y / N	Poliomyelitis:	Y / N	Tuberculosis:	Y / N
Hepatitis:	A / B or C	HIV:	Y / N	Lyme Disease:	Y / N
Diabetes:	Y / N	Any other illnesses not listed: _____			

Prior surgery: _____

_____

Prior hospitalization: _____

_____

Have you ever been treated or are currently being treated for:

Mental Illness: YES / NO Year/s: _____ Head Injury: YES / NO Year/s: _____

Broken bones/Fractures: YES / NO Area of body: _____

REVIEW OF SYSTEMS

EYES, EARS, NOSE AND THROAT

Are you hard of hearing:	YES / NO
Do you have constant ringing in your ears:	YES / NO
Have you at times had bad nose bleeds:	YES / NO
Do you suffer from a constantly runny nose:	YES / NO
Do your eyes continually blink or water:	YES / NO
Do you often see spots before your eyes:	YES / NO
Is your vision poor:	YES / NO
Do you often have pain in your eyes:	YES / NO
Do you suffer from frequent sore throats:	YES / NO
Do you suffer from frequent earaches:	YES / NO

RESPIRATORY

Do you frequently suffer from heavy chest cold:	YES / NO
Do you suffer from asthma:	YES / NO
Are you troubled by constant coughing:	YES / NO
Have you ever coughed up blood:	YES / NO
Have you ever had a chronic chest condition:	YES / NO

CARDIOVASCULAR

Have you ever been told you had heart trouble:	YES / NO	
Do you have pains in the heart or chest:	YES / NO	
Does exercise or excitement cause pain in the chest:	YES / NO	
Are you often bothers by thumping of the heart:	YES / NO	
Has a doctor ever said your blood pressure is low:	YES / NO	
Has a doctor ever said your blood pressure is high:	YES / NO	
Do you often have difficulty breathing:	YES / NO	
Do you often stop for breath when walking upstairs:	YES / NO	How many flights: _____
Have you ever had to sit up to catch your breath:	YES / NO	
Are your ankles often badly swollen:	YES / NO	
Has a doctor every said you had varicose veins:	YES / NO	

GASTROINTESTINAL

Have you ever had unexplained weight loss:	YES / NO
Is your appetite always poor:	YES / NO
Do you usually belch/burp a lot:	YES / NO
Do you usually pass a lot of gas:	YES / NO
Do you suffer from indigestions:	YES / NO
Do you suffer from frequent loose bowels:	YES / NO
Are you constantly constipated:	YES / NO
How may bowel movements do you have:	_____ Daily _____ Weekly
Do you frequently have stomach pains:	YES / NO
Do you have frequent vomiting:	YES / NO
Do you ever vomit blood:	YES / NO
Have you ever passed blood w/bowel movements:	YES / NO

SKIN AND EXTREMITIES

Have you had arthritis or rheumatism: YES / NO
Are your joints often painfully swollen: YES / NO
Do you frequently get severe legs cramps when walking: YES / NO
Do you have any skin rashes: YES / NO
Describe and scars and how acquired: _____
_____

NEUROMUSCULAR

Do you suffer from frequent headaches: YES / NO
Are you usually nervous: YES / NO
Do you often have spells of severe dizziness: YES / NO
Do you frequently feel faint: YES / NO
Have you had a loss of strength/feeling in any part of your body: YES / NO Where: _____
Was any part of your body ever paralyzed: YES / NO Where:_____
Did you ever have a fit or convulsion (epilepsy): YES / NO

HEMATOLOGY

Do you bruise more easily than normal: YES / NO Explain: _____
When you cut yourself do you bleed excessively: YES / NO
Do you have a history of anemia (low blood count): YES / NO

ENDOCRINE

Do you have a history of having thyroid trouble: YES / NO
Where you ever given thyroid tablets to take: YES / NO Currently taking: YES / NO
Are you hypothyroid (underactive): YES / NO
Are you hyperthyroid (overactive): YES / NO

GENITOURINARY

Do you have trouble holding your urine: YES / NO
Have you ever dribbled urine while sneezing: YES / NO
Have you ever had blood or gravel in your urine: YES / NO
Do you often have pain or burning with urination: YES / NO
Have you ever had kidney disease: YES / NO
Do you have trouble starting your stream of urine: YES / NO
How is your energy sexually: _____
Are sexual relations painful or difficult for you: YES / NO
Have you had a recent loss of interest in sexual relations: YES / NO
What form of birth control do you use: _____

WOMENS OBSTETRICS AND GYNECOLOGY

How old were you when you started menstruating: _____
Are your periods regular: YES / NO
When did your last period begin: _____
Usual # days of flow: _____ Usual # of days of cycle: _____
Amount of flow: _____ Color: _____ Clotting: YES / NO
Please describe any discomfort before flow: _____
Please describe any discomfort during flow: _____
Have you ever had vaginal bleeding between your menstrual periods: YES / NO
Do you have vaginal itching or burning: YES / NO
How many pregnancies have you had: _____
How many children have you had: _____
Have you had a miscarriage: YES / NO How many: _____
Do you have any bloody nipple discharge: YES / NO
Are you pregnant or is there any chance that you could be pregnant: YES / NO

MENS REPRODUCTIVE HEALTH

Date of last prostate exam: _____
Results: _____

Please place a check mark next to any symptom or symptoms that you have experienced.

Frequent night-time urination: _____
Delayed urine stream: _____
Dribbling urination: _____
Testicular pain: _____
Erectile dysfunction: _____
Increased libido: _____
Decreased libido: _____
Premature ejaculation: _____
Impotence: _____

INSURANCE INFORMATION

Medical Insurance Carrier: _____ Member ID: _____
Policy holder full name: _____ Policy holder date of birth: _____

All the information that I have provided on pages 1-5 of Acupuncture New Patient has been completed to the best of my knowledge and health history.

_____
Patient name (print)

_____ _____
Patient signature/parent or guardian Date

AUTHORIZATION TO TREAT & EXAMINE

I hereby authorize consultation, examination and treatment by the Amy Annuzzi, MSAC, LAC, LMT at Jersey Wellness Center as they determine appropriate for my medical care and my health concerns.

_____
Patient name (print)

_____ _____
Patient signature/parent or guardian Date

ASSIGNMENT OF BENEFITS TO OUR OFFICE

I hereby authorize direct payment of my insurance reimbursements to Jersey Wellness Center.
I am herein noticed that an insurance company, based on its own policies and guidelines, may make different determinations of the medical necessity of my treatments received at Jersey Wellness Center. This insurance company determination may result in decreased payment or non-payment of some or/all services from my insurance company. I acknowledge that I understand the above statement and agree to be personally responsible for payment of any service/s rendered to me (or my child) by Jersey Wellness Center that is NOT reimbursed by my Insurance Company. I hereby authorize the office of Jersey Wellness Center to release any healthcare information in compliance of HIPAA, to my insurance company, utilization review company or attorney that may be requested.

_____
Patient name (print)

_____ _____
Patient signature/parent or guardian Date

PRIVACY PRACTICES

A copy of our Privacy Practices is available for viewing on our website: www.jerseywellnesscenter.com. In addition, a hard copy is visible in our office. You may request a copy of our Privacy Practices at any time from our front desk.
I have been provided with my options to review a copy of Jersey Wellness Center, LLC Notice of Privacy Practices, which describes Jersey Wellness Center, LLC use and disclosure of my Protected Health Information (PHI)

_____
Patient name (print)

_____ _____
Patient signature/parent or guardian Date