# New Patient Information
## Kate McCarthy, M.S., L. Ac., CMT

**Patient Information**

Name _____ Today's Date _____

Street Address _____ Apt # ____

City _____ State _____ Zip _____

Home phone _(_____)_____ Mobile phone _(____)_____

Other phone _(_____)_____ Email _____

Birth date _____ Age _____ Gender _____

__single __married __domestic partnership __widowed __ other _____

Referred by _____

Emergency Contact _____ Relationship _____

Emergency Contact Phone # _____ mobile # _____

Physician's name _____ phone _____

Date of last visit _____

**Employment**- Please indicate 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 $50 for a 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 _(____)_____

Policy holder's name _____ Policy #/ID# _____

**Super bill requests** __no thank you __once a month __with each treatment

**Missed appointment policy**: if you need to change or cancel your appointment, please do so with 24 hour notice. Failure to do so will result in being charged $85.

_____I understand the cancellation policy.

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**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 ever received acupuncture treament ? _____

If so, for what reason? _____

## Pain

l, r, b= left, right, 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 |
| ___ ___ chest | ___ ___ rib/flank | ___ ___ thigh l r b | ___ ___ toes l r b |
| ___ ___ abdomen | ___ ___ knee l r b | ___ ___ shoulder l r b | |
| ___ ___ upper arm l r b | | ___ ___ calf l r b | ___ ___ elbow 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 |
| ___ ___ bloating | ___ ___ constipation |
| ___ ___ ab pain | ___ ___ blood in stool/black |
| ___ ___ edema | ___ ___ pus in stool |
| ___ ___ fatigue | ___ ___ hemorrhoids |
| ___ ___ low energy | ___ ___ anal fissures |
| ___ ___ crave sweets | __ ___ rectal pain |
| ___ ___ decreased appetite | |
| ___ ___ decreased sense of smell/taste | |
| ___ ___ often feel pensive/thoughtful | |

other current related symptoms _____

# Kate McCarthy, M.S., L. Ac., CMT

Lu

| Past current | past current | past current |
|---|---|---|
| ___ ___ frequent colds | ___ ___ asthma | ___ ___ often feel sad |
| ___ ___ sinus infection | ___ ___ bronchitis | ___ ___ crave spicy foods |
| ___ ___ cough | ___ ___ pneumonia | ___ ___ dry skin |
| ___ ___ cough with blood | ___ ___ COPD | ___ ___ itching |
| ___ ___ production of phlegm | | ___ ___ acne |
| ___ ___ hay fever or allergies | | ___ ___ rashes, hives, eczema or psoriasis |

other current related symptoms _____

K

| Past current | past current | past current |
|---|---|---|
| ___ ___ frequent urination | ___ ___ frequent U.T.I | ___ ___ impotence |
| ___ ___ urgency to urinate | ___ ___ frequent vaginal infections | ___ ___ premature ejaculation |
| ___ ___ pain on urination | ___ ___ pelvic inflammatory disease | ___ ___ testicular lumps |
| ___ ___ urine/bowel incontinence | ___ ___ abnormal PAP | ___ ___ prostatitis |
| ___ ___ weak urine stream | ___ ___ irregular periods | ___ ___ genital itching/pain |
| ___ ___ blood in urine | ___ ___ premenstrual syndrome | ___ ___ genital lesions |
| ___ ___ kidney stones | ___ ___ painful menstrual periods | ___ ___ genital discharge |
| ___ ___ low back pain | ___ ___ abnormal bleeding | ___ ___ low libido |
| ___ ___ sore/weak knees | ___ ___ menopause symptoms | ___ ___ ear ringing: low pitch |
| ___ ___ crave salty foods | ___ ___ breast lumps | ___ ___ ear ringing: high pitch |
| ___ ___ oftern feel afraid | ___ ___ decreased hearing | ___ ___ ear infections |

Total pregnancies _____ Living _____ Ectopic _____ Miscarriages _____
Induced abortions _____

other current related symptoms: _____

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Lv

| Past current | past current | past current |
|---|---|---|
| ___ ___ dry eyes | ___ ___ insomnia | ___ ___ migraine |
| ___ ___ red eyes | ___ ___ excessive/vivid dreams | ___ ___ dizziness |
| ___ ___ eye inflammation | ___ ___ grinding teeth | ___ ___ fainting |
| ___ ___ blurred vision | ___ ___ depression | ___ ___ seizures |
| ___ ___ poor night vision | ___ ___ anxiety/stress | ___ ___ localized weakness |
| ___ ___ floaters (spots in visual field) | ___ ___ irritability | ___ ___ numbness or tingling of limbs |
| ___ ___ visual changes | ___ ___ treated for emotional/ psychological issues | ___ ___ tremors |
| ___ ___ glasses/contact lenses | ___ ___ indecisiveness | ___ ___ poor concentration |
| ___ ___ cataracts | ___ ___ aversion to wind | ___ ___ paralysis |
| ___ ___ crave sour food | ___ ___ often feel angry | ___ ___ tendonitis |
| | | ___ ___ gallstones |

other related symptoms: _____

Ht

| Past current | past current | past current |
|---|---|---|
| ___ ___ high blood pressure | ___ ___ chest pain/pressure | ___ ___ nausea |
| ___ ___ low blood pressure | ___ ___ blood clotting disorder | ___ ___ phlebitis |
| ___ ___ palpitations | ___ ___ jaw ,neck, shoulder or arm pain | ___ ___ poor memory |
| ___ ___ irregular heart beat | ___ ___ swollen hands or feet | ___ ___ crave bitter foods |

other related symptoms: _____

YM

| Past current | past current | past current |
|---|---|---|
| ___ ___ fevers | ___ ___ chills | ___ ___ headache |
| ___ ___ frequent/strong thirst | ___ ___ cold hands/feet | ___ ___ neck stiffness |
| ___ ___ tend to feel warm | ___ ___ tend to feel cold | ___ ___ concussion |
| ___ ___ night sweats | ___ ___ cold sweats | ___ ___ enlarged lymph |
| ___ ___ sweats easily | ___ ___ prefer warm food/drink | |
| ___ ___ prefer cold food/drink | | |

Tumors or lumps _____

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| Past current | past current | past current |
|---|---|---|
| ___ ___ herpes oral/genital | ___ ___ gonorrhea | ___ ___ TB |
| ___ ___ chicken pox | ___ ___ Chlamydia | ___ ___ HIV |
| ___ ___ meningitis | ___ ___ syphilis | |
| ___ ___ hepatitis | ___ ___ genital warts | |

other past or current infectious diseases _____
_____

recent tests and indicate results

cholesterol _____ blood pressure _____ mammography _____

prosate _____ 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 disorder | | | | | | | |
| Bladder disorder | | | | | | | |
| Stomach disorder | | | | | | | |
| 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

_____

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

| | | | |
|---|---|---|---|
| ___ asprin | ___ antacids | ___blood thinners | ___ sleep aid |
| ___ ibuprofen | ___ fiber/laxative | ___ blood pressure med | ___tranquilizers |
| ___acetaminophen | ___diet pills | ___insulin | ___antidepressant |
| ___ clomid | ___ metformin | ___oral contraceptive | ___ allergy medication |

Others, please list _____

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**Medication Allergies** _____

**Food Allergies** _____

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

| | | | |
|---|---|---|---|
| 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 _____

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Please describe your typical daily diet

Breakfast _____ Morning Snack _____

Lunch _____ Afternoon Snack _____

Dinner _____ Evening Snack _____

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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.