WHOLE FAMILY wellness center LLC

Kendra A. Ward, MAOM, L.Ac.
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Adult Health History Intake

PERSONAL & WORK INFORMATION

Patient Name: _____ Date: _____ Date of Injury/Accident: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Birthdate: ____/____/____ Sex: M F Social Security # _____

☐ Married ☐ Partner ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Occupation: _____ Employed By: _____

Business Address: _____ City: _____ State: _____ Zip: _____

How did you learn about our practice? ☐ friend ☐ ad ☐ internet ☐ drive-by ☐ health professional ☐ other:_____

FINANCIAL & INSURANCE INFORMATION

Do you have Medical Insurance that covers Acupuncture? ___Yes ___No If yes, please check type:

☐ Private Health Insurance ☐ Personal Injury (please complete other personal injury forms)

Health Insurance Company _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Adjuster Name: _____

Policy or ID #: _____ Group, Plan or Program: _____ Claim #: _____

Insured Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Partner

Insured Name: _____ Insured: ☐ M ☐ F

Insured Social Security #: _____ Insured Birthdate: _____

Insured Address: _____ City: _____ State: _____ Zip: _____

Insured Phone # : _____ Emergency #: _____

Insured Employer & Address: _____

_____

RECORDS RELEASE & ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to claims for benefits submitted. I further agree and authorize Kendra A. Ward. L.Ac. or Amy E. Chitwood, L.Ac. to submit claims for benefits, for services rendered, without obtaining my signature on each claim. I (patient) _____ hereby authorize (Insurance Co.) _____ to pay and hereby assign directly to Kendra A. Ward. L.Ac. or Amy E. Chitwood, L.Ac. all owed benefits. I understand that I am financially responsible for all charges incurred, whether or not they are covered by my insurance company. This authorization shall remain valid until written notice is given by me revoking said authorization.

Signature of Patient _____ Date _____

Adult Health History Intake (continued)

Patient name_____ Birth date_____

Primary complaint_____

History of present illness:

Where does it hurt? _____
How long have you had this problem? _____
What does it feel like when it hurts? _____
Does the pain/problem occur at a specific time? _____
What other associated problems have you been having? _____
What makes the pain/problem worse or better? _____

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State

Medications (include non-prescription, vitamins, supplements, etc.) _____

Family Medical History

	age	diseases	if deceased, cause of death
Father			
Mother			
Siblings			
Spouse			
Children			

Please mark an "x" next to any conditions you have had and a 'check' after conditions you currently have.

MENTAL/EMOTIONAL
____ Mood swings/depression
____ Eating disorder
____ History of counseling
____ Tension
____ Anxiety or nervousness
____ Considered/attempted suicide

NEUROLOGIC
____ Seizures
____ Vertigo or dizziness
____ Paralysis
____ Muscle weakness
____ Numbness or tingling
____ Loss of balance
____ Loss of memory

RESPIRATORY
____ Cough
____ Pain on breathing
____ Wheezing or asthma
____ Shortness of breath
____ Bronchitis
____ Spitting up blood

ENDOCRINE
____ Thyroid problems
____ Heat or cold intolerance
____ Fatigue
____ Hypoglycemia
____ Excess thirst or hunger
____ Diabetes
____ Seasonal depression

SKIN
____ Rashes
____ Color change
____ Eczema
____ Fungus
____ Itching
____ Acne or boils

NOSE AND SINUSES
____ Stuffiness
____ Nose Bleeds
____ Hay fever
____ Sinus problems
____ Loss of smell
____ Sinus headaches

IMMUNE
____ Chronic fatigue syndrome
____ Chronically swollen glands
____ Chronic infections
____ Frequent colds
____ Autoimmune disease
____ Allergies or hay fever

HEAD
____ Headaches
____ Migraines
____ Head Injury
____ Jaw/TMJ problems

EARS
____ Impaired hearing
____ Earaches
____ Ringing

Adult Health History Intake (continued)

Patient name_____ Birth date_____

MOUTH AND THROAT
____ Teeth grinding
____ Hoarseness
____ Copious saliva
____ Dry mouth
____ Gum problems
____ Sore tongue or lips
____ Frequent sore throat
____ Mouth sores

EYES
____ Floaters or 'spots'
____ Cataracts
____ Blurriness
____ Double Vision
____ Glaucoma
____ Near/Far sightedness
____ Tearing or dryness
____ Eye pain/strain
____ Impaired vision

MUSCULOSKELETAL
____ Joint pain
____ Joint stiffness
____ Arthritis
____ Weakness
____ Sciatica
____ Broken bones
____ Muscle pain
____ Muscle spasm
____ Osteoporosis

URINARY/KIDNEY
____ Pain on urination
____ Increased frequency
____ Frequency at night
____ Kidney stones
____ Infections
____ Urine leakage

CARDOVASCULAR
____ Heart disease
____ Murmurs
____ Chest pain
____ Poor circulation
____ Blood clots
____ Deep leg pain
____ Valvular problems

____ Palpitations
____ Easy bruising
____ Anemia
____ Varicose veins
____ Fainting
____ Swelling in ankles

REPRODUCTIVE
____ Pain with intercourse
____ Chlamydia
____ Herpes
____ Genital warts
____ Discharge or sores
____ Sexual difficulties
____ Trouble conceiving

GASTROINTESTINAL
____ Trouble swallowing
____ Nausea
____ Vomiting
____ Diarrhea
____ Belching
____ Passing gas
____ Change in appetite

____ Heartburn
____ Ulcer
____ Change in thirst
____ Hemorrhoids
____ Pain or cramps
____ Black stool
____ Blood in toilet

FEMALE ONLY
____ How many days of bleeding per cycle?
____ Are cycles regular?
____ PMS
____ Length of cycle (days)
____ Bleeding between cycles
____ Discharge
____ Painful menses
____ Endometriosis
____ Menopause symptoms
____ Breast lumps or pain
____ Nipple discharge
____ Do you do self breast exams?

____ Age of first menses
____ Clotting
____ Heavy cycles
____ Abnormal paps
____ Ovarian cysts
____ # of pregnancies
____ # of miscarriages
____ # of live births
____ # of abortions

MALE ONLY
____ Hernias
____ Testicular mass
____ Prostate disease
____ Impotence
____ Testicular pain
____ Premature ejaculation

HABITS
Do you exercise? _____ If yes, what kind and how often? _____
Do you have a spiritual practice? _____ If yes, what kind? _____
How many hours do you sleep? _____ Do you sleep well? _____ Use recreational drugs? _____
Drink coffee? _____ Drink cola? _____ Eat 3 meals a day? _____
Use tobacco? _____ Use alcoholic beverages? _____
How much water do you drink daily? _____
Food intolerances (if known) _____

A few final questions:
1. How does your health condition affect your life on an ongoing basis? _____
_____
_____
2. How would your life be different if you didn't have this condition? _____
_____
_____
3. On a scale of 1-10, how committed are you to improving your state of health? _____
4. On a scale of 1-10, how much change are you willing to make at this time for improving your state of health? ____