Acupuncture & Cupping

1300 W. Gonzales Rd. Suite 102A
Oxnard, CA 93036
Phone: 805-407-1034

What are your goals for your healthcare here at our office?

☐ Wellness / Preventative Care ☐ Pain Management ☐ Personal Injury ☐ Work Injury ☐ Other _____

PATIENT INFORMATION

DATE:_____

Name_____
Last First

Sex: ☐ M ☐ F **Age**_____ **Birth date**_____/_____/_____

Address:_____

_____
City State Zip Code

Home Phone #: (_____)_____

Cell Phone #: (_____)_____

E-mail address: _____

Occupation: _____ FT / PT

Employer: _____

Employer's Address: _____

Whom may we thank for referring you? _____

Spouse -OR- Parent (if patient is a minor)

Name: _____
Last First

Birth date ____/_____/____Phone Number: (____)_____

Previous Doctors

Chiropractor

_____
Name Phone #

Date of last Visit:_____

Reason for last visit:_____

Medical Doctor

_____
Name Phone #

Date of last visit:_____

Reason for last visit:_____

Accident Information

Is this condition due to an accident? ☐ Yes ☐ No

Date of accident _____/_____/_____ Type _____

Attorney
Name_____

Phone Number: (_____)_____

Emergency Contact

Name:_____

Phone #: _____

Phone #: _____

Relationship: _____

PAST HISTORY

Accidents:	Medications:
Surgeries:	Supplements:
Hospitalizations:	Other:

Are you pregnant? ☐ Yes ☐ No Week # _____
Are you nursing? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No Packs per day _____
Drink caffeine? ☐ Yes ☐ No Cups per day _____

Ever been pregnant? ☐ Yes ☐ No If yes, number of births _____
Are you allergic to anything? ☐ Yes _____ ☐ No
Do you drink alcohol? ☐ Yes ☐ No Drinks per week _____
Do you exercise? ☐ Yes ☐ No Hours per week _____

Chief Complaint(s): _____

_____

Where exactly is the problem? _____ When did the problem begin? _____

Have you ever experiences this problem before? (Yes / No) When? _____

Do you have X-Rays/MRI/Ultrasound results for this problem? _____

Is this problem getting worse? Yes / No / Not sure

Rate your pain: (No Pain) 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 (Worst Pain)

Does anything make it: Worse? _____ Better? _____

For the following questions check all that apply.
Type of Pain:
☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Burning ☐ Shooting ☐ Tingling
☐ Cramps ☐Other: _____

Does it interfere with your:
☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform:
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Lifting ☐ Other: _____

***Please check all conditions that you are experiencing or have experienced, even if they seem unrelated to your problem area*:**

☐ Neck pain or stiffness	☐ Sexually Transmitted Dis.	☐ Thyroid Disorder	☐ Measles/Mumps
☐ Back Pain	☐ Menstrual pain	☐ Pneumonia	☐ Epilepsy or Seizures
☐ Mid Back Pain	☐ Menstrual Irregularity	☐ Constipation	☐ Double Vision
☐ Low Back Pain	☐ Hot Flashes	☐ Diarrhea	☐ Ringing in ears
☐ Upper extremity pain	☐ Fatigue	☐ Fever	☐ Loss of taste
☐ Lower extremity pain	☐ Nausea	☐ Irritability	☐ Loss of smell
☐ Headaches / Migraines	☐ Heartburn	☐ High Blood Pressure	☐ Loss of balance
☐ Tension	☐ Hepatitis	☐ Ulcers	☐ Cold sweats
☐ Depression	☐ HIV/AIDS	☐ Stomach upset	☐ Numbness in legs
☐ Dizziness	☐ Cancer	☐ Appendicitis	☐ Numb/cold feet
☐ Fainting	☐ Stroke	☐ Anal fissures	☐ Cold hands
☐ Nervousness	☐ Gout	☐ Problem urinating	☐ Numbness in fingers
☐ Sleeping problems	☐ Tuberculosis	☐ Increase in thirst	☐ Pins and needles

Have you ever been diagnosed with an illness? (i.e. Cancer, Arthritis, Heart disease, Scoliosis, MS, etc.)? _____
If yes, please list here: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes. I authorize the Doctor, and staff to perform any necessary services that I may need during diagnosis and treatment with my informed consent.

Patient's Signature: _____ Date: _____