



Dancing Bear Healing Center
Confidential Patient Information Sheet

Patient Information

Name _____ Date _____
Address _____ City _____ State _____
Zip _____ Home phone _____ Work phone _____ Cell _____
Email _____ Have you had acupuncture before? Yes No
Height _____ Weight _____ Age _____ Sex: Male Female Date of birth _____
Occupation _____ Employer _____
In emergency notify (name): _____ Emergency phone number: _____
Marital Status: Single Married Domestic Partner Divorced Widowed Separated
Number of children: _____ Ages of children: _____ Number who live with you: _____
Others living with you: _____
Primary Care Doctor _____ Last seen: _____
How did you hear about Dancing Bear Healing Center: Meetup Article A Talk Brochure
 Business Card Web site Web Search Referred by: _____

Medical History

Reason for your visit today: _____

Are you being treated for this condition by anyone else: Yes No
If Yes, who? _____ Phone number: _____
Has this condition been diagnosed by a MD? No Yes - Diagnosis: _____
Have these treatments helped? Yes Somewhat Not much Not at all
How does this condition affect you? _____
How long have you had this condition? _____
Do you currently have any infectious diseases? Yes No Possibly
If Yes, please identify: HIV + Hepatitis B Hepatitis C Flu / Cold Streptococcus
 Mononucleosis Tuberculosis Other: _____
Known or suspected allergies: _____
Childhood diseases you have had: Chicken Pox Measles Mumps Rheumatic Fever
 Diphtheria Scarlet Fever Other _____
Accidents / Hospitalizations / Surgeries in the past 10 years:
Reason _____ Date / Year(s) _____

Your general health as a child: Excellent Good Average Poor



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Health Inventory

<p><u>Cardiovascular</u> Conditions:</p> <input type="checkbox"/> Heart Disease <input type="checkbox"/> A Pacemaker <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Stroke <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Edema	<p><u>Emotional / Mental:</u></p> <input type="checkbox"/> Clinical Depression <input type="checkbox"/> Mild Depression <input type="checkbox"/> ADD or ADHD <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Mood Swings <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Nervousness <input type="checkbox"/> Anxiety <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Dementia	<p><u>Energy & Immunity:</u></p> <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> General Fatigue <input type="checkbox"/> Slow Wound Healing <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Chronic Infections <input type="checkbox"/> Frequent Allergies	<p><u>Respiratory:</u></p> <input type="checkbox"/> Pneumonia <input type="checkbox"/> Asthma <input type="checkbox"/> Frequent Common Colds <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Emphysema <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Pleurisy <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Shortness of Breath
<p><u>Musculo-Skeletal:</u></p> <input type="checkbox"/> Neck / Shoulder Pain <input type="checkbox"/> Muscle Spasms / Cramps <input type="checkbox"/> Arm Pain <input type="checkbox"/> Elbow Pain <input type="checkbox"/> Wrist Pain <input type="checkbox"/> Upper Back Pain <input type="checkbox"/> Mid Back Pain <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Leg Pain <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Hip Pain <input type="checkbox"/> Knee Pain <input type="checkbox"/> Ankle Pain <input type="checkbox"/> Other Pain	<p><u>Head, EENT</u></p> <input type="checkbox"/> Impaired Vision <input type="checkbox"/> Eye Pain/Strain <input type="checkbox"/> Glaucoma <input type="checkbox"/> Glasses / Contacts <input type="checkbox"/> Tearing / Dryness <input type="checkbox"/> Impaired Hearing <input type="checkbox"/> Ear Ringing <input type="checkbox"/> Earaches <input type="checkbox"/> Ear Infections <input type="checkbox"/> Headaches <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Teeth Grinding <input type="checkbox"/> Frequent Sore Throats <input type="checkbox"/> TMJ / Jaw Problems <input type="checkbox"/> Hay Fever	<p><u>Genital-Urinary Tract:</u></p> <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Painful Urination <input type="checkbox"/> Dribbling Urination <input type="checkbox"/> Frequent UTI <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Discharge <input type="checkbox"/> Incontinence <p><u>Neurological:</u></p> <input type="checkbox"/> Vertigo / Dizziness <input type="checkbox"/> Paralysis <input type="checkbox"/> Numbness / Tingling <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Seizures / Epilepsy <input type="checkbox"/> Dyslexia	<p><u>Gastrointestinal:</u></p> <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Other Ulcers <input type="checkbox"/> Changes in Appetite <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Epigastric / Abdominal Pain <input type="checkbox"/> Passing Gas <input type="checkbox"/> Heart Burn <input type="checkbox"/> Belching <input type="checkbox"/> Gall Bladder Disease <input type="checkbox"/> Gall Bladder Stones <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea
<p><u>Endocrine:</u></p> <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Diabetes Type I <input type="checkbox"/> Diabetes Type II <input type="checkbox"/> Night Sweats <input type="checkbox"/> Unusual Sweating <input type="checkbox"/> Feeling Hot or Cold	<p><u>Other:</u></p> <input type="checkbox"/> Cancer /Type: _____ <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Lupus <input type="checkbox"/> Candida <input type="checkbox"/> Anemia <input type="checkbox"/> Rashes <input type="checkbox"/> Eczema / Hives <input type="checkbox"/> Cold Hand / Feet <input type="checkbox"/> Hemophilia <input type="checkbox"/> Thin / Graying hair	<p><u>Liver Conditions:</u></p> <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Sclerosis	<p><u>Men Only:</u></p> <input type="checkbox"/> Impotence <input type="checkbox"/> Vasectomy Date: _____ <input type="checkbox"/> Prostate problems <input type="checkbox"/> Testicular Pain / Redness / Swelling <input type="checkbox"/> Low libido <input type="checkbox"/> Excessive libido <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Seminal emissions

Women Only:

Are you pregnant right now? Yes No Trying Maybe Method of Birth Control: _____

Age at first period: _____ Date of last menses: _____ Age at menopause: _____

Typical length of menses (days): _____ Typical length of cycle (from 1st day to 1st day of menses): _____ Number of: _____ Pregnancies: _____ Births: _____ Abortions: _____ Miscarriages: _____ Hysterectomy: Yes No Date: _____

Check all that apply: Low libido Excessive libido Painful Intercourse Clotting Painful Periods Heavy Flow Scanty Flow Bleeding Between Cycles Irregular Cycles Vaginal Discharge Breast Lumps / Tenderness Nipple Discharge Infertility Menopausal Symptoms Premenstrual Problems



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Medications

Please list all prescription and over the counter medications you are currently taking:

Drug Name	Reason for Taking	For How Long	Dose	Frequency
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Please list all supplements and herbs you are currently taking:

Supplement	Reason for Taking	Potency	Frequency
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Lifestyle

(Daily amount used within the past 2 months)

Tobacco: Yes No Amount: _____ Alcohol: Yes No Amount: _____

Coffee: Yes No Amount: _____ Recreational Drugs: Yes No Amount: _____

Do you feel you are at or near your ideal weight? Yes No Ideal Weight? _____ (lbs)

Do you feel you have enough energy? Yes No Are you vegetarian or vegan? Yes No

Best time of day: _____ Worst time of day: _____

Favorite Season: _____ Hours of sleep at night: _____

Do you feel rested after a night's sleep? _____ Do you remember your dreams? _____

Typical day's meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks / Other: _____

Food cravings: _____

Religion or other spiritual practice: _____

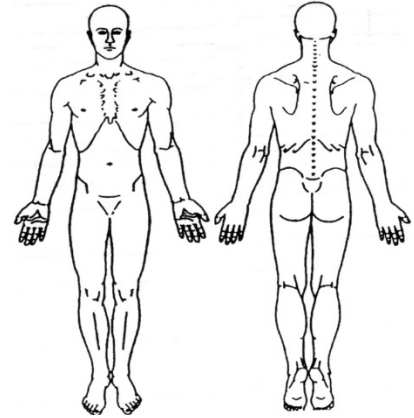
What kind of physical exercise to you do regularly? _____



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Pain

Use the diagram if desired to indicate location of pain or other conditions.



Payment

Payment is due at time of service. If you have insurance we will be happy to provide you with a Superbill that you may use to submit to your insurance carrier.

The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Dancing Bear Healing Center 24 hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged \$25 for the missed appointment.

Appointment reminders are sent via email and Text Message from SquareUp.com. I understand that this will be my only appointment reminders.

X Signed: _____ Date: _____

Parent / Guardian (if applicable) _____