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

Cardiovascular Conditions:
- ☐ Heart Disease
- ☐ A Pacemaker
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Edema

Emotional / Mental:
- ☐ Clinical Depression
- ☐ Mild Depression
- ☐ ADD or ADHD
- ☐ Schizophrenia
- ☐ Mood Swings
- ☐ Panic Attacks
- ☐ Nervousness
- ☐ Anxiety
- ☐ Alzheimer's
- ☐ Dementia

Energy & Immunity:
- ☐ Chronic Fatigue Syndrome
- ☐ General Fatigue
- ☐ Slow Wound Healing
- ☐ Easy Bruising
- ☐ Chronic Infections
- ☐ Frequent Allergies

Respiratory:
- ☐ Pneumonia
- ☐ Asthma
- ☐ Frequent Common Colds
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Persistent Cough
- ☐ Pleurisy
- ☐ Tuberculosis
- ☐ Shortness of Breath

Musculo-Skeletal:
- ☐ Neck / Shoulder Pain
- ☐ Muscle Spasms / Cramps
- ☐ Arm Pain
- ☐ Elbow Pain
- ☐ Wrist Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Leg Pain
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Ankle Pain
- ☐ Other Pain

Head, EENT
- ☐ Impaired Vision
- ☐ Eye Pain/Strain
- ☐ Glaucoma
- ☐ Glasses / Contacts
- ☐ Tearing / Dryness
- ☐ Impaired Hearing
- ☐ Ear Ringing
- ☐ Earaches
- ☐ Ear Infections
- ☐ Headaches
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Teeth Grinding
- ☐ Frequent Sore Throats
- ☐ TMJ / Jaw Problems
- ☐ Hay Fever

Genital-Urinary Tract:
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Painful Urination
- ☐ Dribbling Urination
- ☐ Frequent UTI
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Discharge
- ☐ Incontinence

Neurological:
- ☐ Vertigo / Dizziness
- ☐ Paralysis
- ☐ Numbness / Tingling
- ☐ Loss of Balance
- ☐ Seizures / Epilepsy
- ☐ Dyslexia

Gastrointestinal:
- ☐ Stomach Ulcers
- ☐ Other Ulcers
- ☐ Changes in Appetite
- ☐ Nausea / Vomiting
- ☐ Epigastric / Abdominal Pain
- ☐ Passing Gas
- ☐ Heart Burn
- ☐ Belching
- ☐ Gall Bladder Disease
- ☐ Gall Bladder Stones
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Diarrhea

Endocrine:
- ☐ Hypothyroid
- ☐ Hypoglycemia
- ☐ Hyperthyroid
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Night Sweats
- ☐ Unusual Sweating
- ☐ Feeling Hot or Cold

Other:
- ☐ Cancer /Type:_____
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Candida
- ☐ Anemia
- ☐ Rashes
- ☐ Eczema / Hives
- ☐ Cold Hand / Feet
- ☐ Hemophilia
- ☐ Thin / Graying hair

Liver Conditions:
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Sclerosis

Men Only:
- ☐ Impotence
- ☐ Vasectomy Date: _____
- ☐ Prostate problems
- ☐ Testicular Pain / Redness / Swelling
- ☐ Low libido
- ☐ Excessive libido
- ☐ Painful Intercourse
- ☐ 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

Please list all supplements and herbs you are currently taking:

Supplement	Reason for Taking	Potency	Frequency

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 nights 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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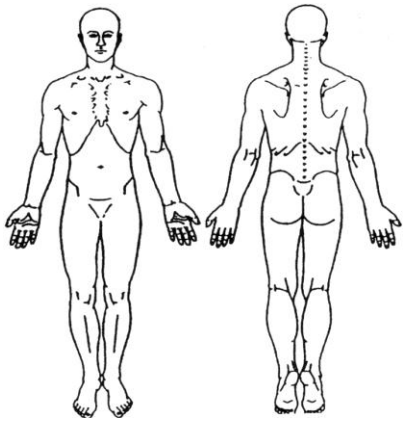
Pain

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 bill them for you and they can reimburse you. There are no discounts for services that use insurance.

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 for the appointment.

X Signed: _____ Date: _____

Parent / Guardian (if applicable) _____

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