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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Phone: 480-422-7000 for Appointments, www.DBHealingCenter.com

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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

Medications

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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? _____

Pain

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

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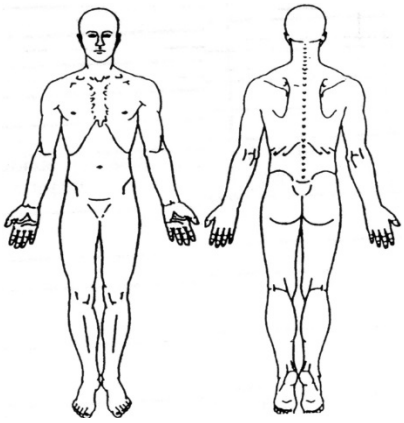

Payment

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 from sales@DBHealingCenter.com. I understand that this will be my only reminder of my appointment.

X Signed: _____ Date: _____

Parent / Guardian (if applicable) _____

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