Acupuncture . Nutrition . Chiropractic

CONFIDENTIAL PATIENT CASE HISTORY

Name: _____

Address: _____

City: _____ST: _____ZIP:_____

Home Phone: ( ) _____Business/Cell Phone: ( ) _____

Birth date: _____Age:_____Occupation: _____

Social security #: _____

Martial Status:_____Spouses Name:_____# of Children: _____

E-Mail: _____Referred by:_____

Nearest Relative _____Phone: ( ) _____

HEALTH INFORMATION:

What are your major symptoms (complaints) in priority? _____

_____

_____

Other doctors who have treated these conditions? (Please include approx. dates) _____

_____

_____

Please List any vitamins and/or medications you are currently taking: _____

_____

_____

Please List Any surgeries & dates: _____

_____

_____

Have you ever experienced a personal injury (automobile, fall) & date:

_____

_____

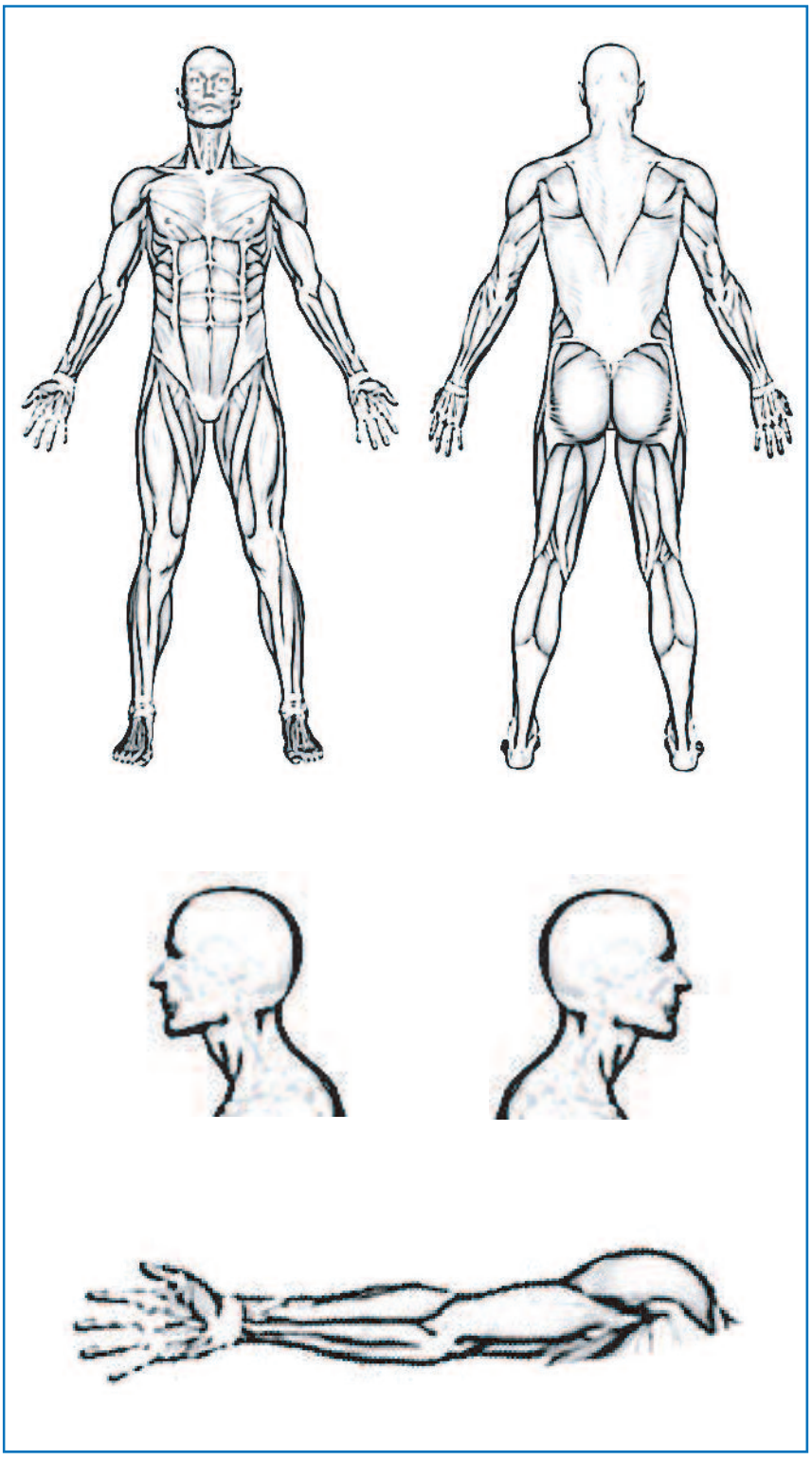
_____

Have you ever suffered from:		*In the past 6 months:*
Alcoholism	☐	☐
Allergies	☐	☐
Anemia	☐	☐
Arteriosclerosis	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Back Pain	☐	☐
Breast lump	☐	☐
Bronchitis	☐	☐
Bruise Easily	☐	☐
Cancer	☐	☐
Chest Pain/Conditions	☐	☐
Cold extremities	☐	☐
Constipation	☐	☐
Cramps	☐	☐
Depression	☐	☐
Diabetes	☐	☐
Digestion Problems	☐	☐
Dizziness	☐	☐
Ears Ring	☐	☐
Excessive Menstruation	☐	☐
Eye Pain/Difficulties	☐	☐
Fatigue	☐	☐
Frequent Urination	☐	☐
Headache	☐	☐
Hemorrhoids	☐	☐
High Blood Pressure	☐	☐
Hot Flashes	☐	☐
Irregular Heart Beat	☐	☐
Irregular Cycle	☐	☐
Kidney Infection	☐	☐
Kidney Stones	☐	☐
Loss of memory	☐	☐
Loss of balance	☐	☐
Loss of smell	☐	☐
Loss of taste	☐	☐
Lumps In Breast	☐	☐
Neck Pain or Stiffness	☐	☐
Nervousness	☐	☐
Nosebleeds	☐	☐
Pacemaker	☐	☐
Polio	☐	☐
Poor Posture	☐	☐
Prostate Trouble	☐	☐
Sciatica	☐	☐
Shortness of breath	☐	☐
Sinus Infection	☐	☐
Sleep problems/insomnia	☐	☐
Spinal Curvatures	☐	☐
Stroke	☐	☐
Swelling of ankles	☐	☐
Swollen Joints	☐	☐
Thyroid Condition	☐	☐
Tuberculosis	☐	☐
Ulcers	☐	☐
Varicose Veins	☐	☐
Venereal Disease	☐	☐
Other:	☐	☐

CURRENT COMPLAINTS (CONTINUED)

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
B=Burnin
N=Numbnes
O=Other
P=Pins & Needles
S=Stabbing



FAMILY HISTORY

Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

HABITS:	NONE	LIGHT	MODERATE	HEAVY
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

	Yes	No
Do you experience pain every day?	☐	☐
Do your symptoms interfere with daily life?	☐	☐
Does pain wake you up at night?	☐	☐
Are your symptoms worse during certain times of the day?	☐	☐
Do changes in weather affect your symptoms?	☐	☐
Do you wear orthotics?	☐	☐
Do you take vitamin supplements?	☐	☐

What activities aggravate your symptoms?

_____

_____

_____

Office Policies

Appointments
Our office requires a 24hr cancellation notice. Failure to show up for your appointment without a phone call will result in a $65 minimal office fee.

Wardrobe
It is important when you come in for a visit at our Wellness Center that you dress the part. Acupuncture needles may be placed in your ears, hands, feet, legs and face. Wearing pantihose or other restrictive clothing holds up the treatment process. Also please reframe from wearing an excessive amount of jewelry as it interferes with our AcuGraph testing.

Office Etiquette
At our Wellness Center it is important that we respect the other patients who are being treated. Cell phone usage is not permitted in our office.

Payment
Payment is due at time of service with no exceptions. Our office accepts cash, all major credit cards, personal and business checks.

Health Insurance
Due to ever increasing resistance from insurance companies, combined with the uniqueness of our services we are unable to accept Health Insurance as a form of payment.

We can provide you with paper work so that your insurance company may reimburse you depending upon your agreement with them.

Make sure you ask for your forms prior to leaving the office.

Electronic Mail
From time to time, Dr. Karp's Wellness Center may use your personal information to contact you by electronic mail concerning your treatment as well as our services. These communications are intended to inform you of information regarding our office, or about general services provided by Dr. Karp's Wellness Center. If you do not want to receive email from us regarding our services and your care, please reply to the e-mail with unsubscribe in the subject line and your e-address will be removed from our file.

Confidentiality
Patient confidentiality as required by state law is maintained at all times.

I _____ have read the above information. I also acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Signature Date