SORRENTO VALLEY
CHIROPRACTIC

5440 Morehouse Drive, Suite 1700
San Diego, CA 92121

ACUPUNCTURE NEW PATIENT INFORMATION

Date: _____

PERSONAL INFORMATION

Name: _____ D.O.B._____

Address:_____

City:_____State:_____Zip:_____

Home Ph (landline or cell):_____ Work Ph:_____

Is it okay to text? (Appointment reminders only) Yes ☐ No ☐

Email: _____

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Employer: _____

Occupation: _____

Insurance Plan: _____

Primary Doctor: _____ Phone: _____

Height:_____ Weight:_____ (for insurance purposes) Male ☐ Female ☐

Have you had acupuncture before? Yes ☐ No ☐

Is your condition the result of a(n): Work Injury ☐ Auto Accident ☐ If so date of injury:_____

REFERRAL INFORMATION (Circle one and specify below)

Patient/Friend/Family Insurance referral Website Yelp/Google

Comments: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Contact Ph: _____

Medical Information:

Please indicate any significant illnesses you or a blood relative (parent, sibling) have had:

Illness	You	Your relative	Illness	You	Your relative
Anemia	☐	☐	Heart disease	☐	☐
Auto-immune disorder	☐	☐	Hearing problem	☐	☐
Bleeding disorder	☐	☐	High blood pressure	☐	☐
Cancer	☐	☐	Infectious disease	☐	☐
Circulatory problem	☐	☐	Lung problem	☐	☐
Diabetes (Type I or II)	☐	☐	Reproductive disorder	☐	☐
Emotional disorder	☐	☐	Seizure disorder	☐	☐
Hepatitis	☐	☐	Thyroid problem	☐	☐
			Tuberculosis	☐	☐

Comments:_____

Please indicate if you have a Sexually Transmitted Disease: Gonorrhea □ Syphilis □
AIDS/HIV □ HPV □ Chlamydia □ Herpes □

List any allergies (drugs, chemicals, foods):_____

_____

List any accidents, surgeries, or hospitalizations:_____

_____

Medications you are currently taking:

Medication	Dosage	Reason for taking	How long

Habits: Please mark any of the habits listed below which apply to you:

Smoking: Yes □ No □ If yes, # of cigarettes per day:_____
Alcohol: Yes □ No □ If yes, # drinks per week:_____
Caffeine: Yes □ No □ If yes, # coffee/tea/sodas per day:_____
How much water do you drink? _____

Do you: bruise easily □ have a pacemaker □ have a nerve stimulator □
have an insulin pump □

PRESENT COMPLAINTS:

Conditions	Date Began?	Severity	Frequency
Please list your reasons for coming in (health conditions) in the order of importance	Onset of symptom	Rate pain or symptoms from "0" none to "10" severe None……Severe	Please check box that best represents the amount of time you feel your pain or symptoms
1		0 1 2 3 4 5 6 7 8 9 10	☐0-25% □ 26-50% □51-75% □ 76-100%
2		0 1 2 3 4 5 6 7 8 9 10	☐0-25% □ 26-50% □51-75% □ 76-100%
3		0 1 2 3 4 5 6 7 8 9 10	☐0-25% □ 26-50% □51-75% □ 76-100%
4		0 1 2 3 4 5 6 7 8 9 10	☐0-25% □ 26-50% □51-75% □ 76-100%

List your daily activities that are limited because of your symptoms:

1._____

2._____

3._____

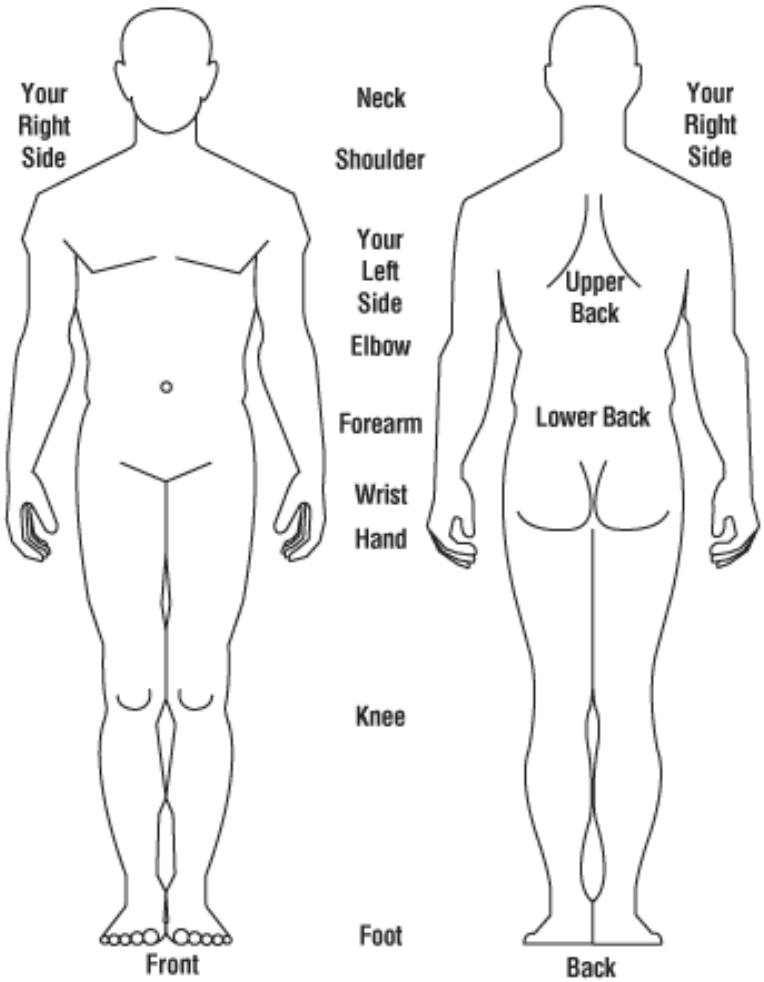
What are your goals in regards to your treatments:

_____

_____

_____

MARK AREAS OF PAIN ON DIAGRAM BELOW (circle or mark an X):



Signature:_____ Date:_____