Hidden Rhythm Acupuncture

Craig Amrine, L.Ac.
4645 S. Lakeshore Dr. Suite 7
Tempe, AZ
85282

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

Primary Care Doctor _________________________________ Last seen: _______________

How did you hear about our clinic: ☐ Yellow Pages ☐ New Vision Ad ☐ Article ☐ A Talk

☐ Brochure ☐ Business Card ☐ Web site ☐ New Times Ad ☐ Referred by: ________________

Medical History

Reason for your visit here 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? ☐ Yes (Diagnosis: ________________________) ☐ No

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

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

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

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: _______________________________________

Hobbies or other recreation: ____

What kind of physical exercise to you do regularly? ___________________________

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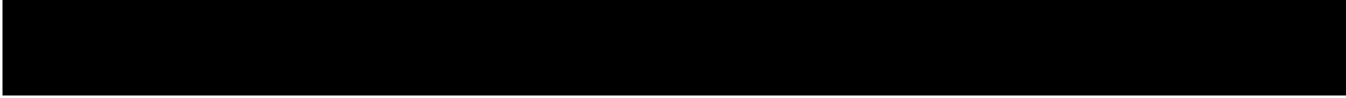

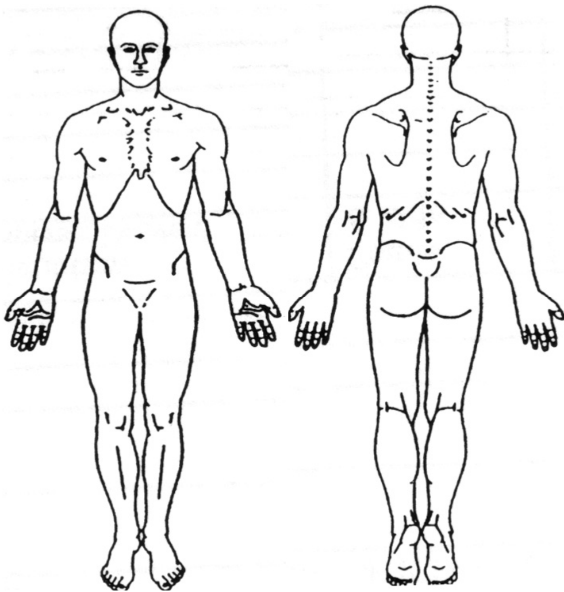

The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Oasis Acupuncture 24 hours prior to any cancellations 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) ____

Would you like to receive a free email newsletter? ☐ Yes ☐ No