Patient Information
Liat Barnea M.S., L.Ac.

Patient's Name _____ Today's Date _____

Street Address _____ City, State _____

Zip _____ Cell Phone (___) _____ Place of birth _____

Email _____ Birth Date _____ Age ___ Gender _____

Referred by _____

Emergency Contact _____ Relationship _____

Emergency Contact Cell #(___) _____

Physician's Name _____ Phone(___) _____

Date of last visit _____

Employment – Please check all that apply

☐ full-time ☐ part-time ☐ self-employed ☐ unemployed ☐ retired

Occupation _____ # hours work/study per week _____

Employer's Name _____ Phone(___) _____

Billing

Payment in full is due at the time services are rendered. Office visits are $115, with an additional $60 fee for the first visit. Please allow 1.5 hours for the first visit, and approximately one hour for each visit thereafter.

Missed Appointment Policy

If you need to change or cancel your appointment please do so with 48 hours notice. Failure to do so will result in being charged for the full fee of the appointment.

____ **I understand cancellation policy** *(please initial)*

Insurance Company Name _____ Patient's Subscriber ID _____

Main Subscriber Name: _____

Main Subscriber ID _____ Main Subscriber Date of Birth _____

Confidentiality

Your patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by your authorization, or when required or permitted by law.

patient: _____

Health History

Patient Name_____Date_____

Have you had acupuncture treatment before? If so, for what reason(s)?

_____

_____

Pain

Circle **L** for left and **R** for right side of body, or circle both where applicable

☐ Head L R	☐ Forearm L R	☐ Upper back L R	☐ Shin L R
☐ Jaw L R	☐ Wrist L R	☐ Mid-back L R	☐ Ankle L R
☐ Neck L R	☐ Hand L R	☐ Low back L R	☐ foot L R
☐ Throat L R	☐ Fingers L R	☐ Hip L R	☐ Heel L R
☐ Shoulder L R	☐ Chest L R	☐ Thigh L R	☐ Toes L R
☐ Upper arm L R	☐ Rib/flank L R	☐ Knee L R	
☐ elbow L R	☐ abdomen L R	☐ Calf L R	

Stomach/Spleen

- ☐ Nausea/vomiting
- ☐ Belching/burping
- ☐ Heartburn
- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Ulcers
- ☐ Excessive appetite
- ☐ Low/no appetite
- ☐ Change in appetite
- ☐ Difficulty swallowing
- ☐ Recurring sore throat
- ☐ Laryngitis/hoarse voice
- ☐ Abdominal pain
- ☐ Gas
- ☐ Abdominal bloating
- ☐ Indigestion
- ☐ Low energy/fatigue
- ☐ Craving sweets
- ☐ Descreased sense of tastes/smell
- ☐ Sweet taste in mouth
- ☐ Nose bleeds
- ☐ Edema (swelling)
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood or black in stools
- ☐ Pus in stools
- ☐ Hemorrhoids
- ☐ Anal fissures
- ☐ Rectal pain
- ☐ Frequently feel lost in thought

Lung

- ☐ Frequent colds
- ☐ Sinus infection
- ☐ Cough
- ☐ Cough with blood
- ☐ Production of phlegm
- ☐ Hayfever or allergies
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ COPD
- ☐ Rashes, hives, eczema, or psoriasis
- ☐ Often feel sad
- ☐ Crave pungent foods
- ☐ Dry skin
- ☐ Itching
- ☐ Acne

Liver

- ☐ Dry eyes
- ☐ Red eyes
- ☐ Eye inflammation
- ☐ Blurred vision
- ☐ Poor night vision
- ☐ Insomnia
- ☐ Excessive or vivid dreams
- ☐ Grinding teeth
- ☐ Depression
- ☐ Floaters (spots in the visual field)
- ☐ Anxiety/stress
- ☐ Irritability
- ☐ Indecisiveness
- ☐ Often feel angry
- ☐ Migraines
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Localized weakness
- ☐ Treated/taken medications for emotional/psychological issues
- ☐ Numbness or tingling of limbs
- ☐ Tremors
- ☐ Poor Concentration
- ☐ Paralysis
- ☐ Aversion to wind
- ☐ Tendonitis
- ☐ Gallstones

patient: _____

Kidney

- ☐ Frequent urination
- ☐ Urgency to urinate
- ☐ Pain on urination
- ☐ Urine/bowel incontinence
- ☐ Weak urine stream
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Low back pain
- ☐ Sore/weak knees
- ☐ Crave salty foods
- ☐ Often feel afraid
- ☐ Frequent urinary tractinfections
- ☐ Frequent vaginal infections
- ☐ Pelvic inflammatory disease
- ☐ Abnormal PAP smear
- ☐ Irregular periods
- ☐ Premenstrual syndrome
- ☐ Painful menstrual periods
- ☐ Abnormal bleeding
- ☐ Menopause symptoms
- ☐ Breast lumps
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Testicular lumps
- ☐ Prostatitis
- ☐ Genital itching/pain
- ☐ Genital lesions/discharge
- ☐ decreased libido
- ☐ ear ringing - low pitch
- ☐ ear ringing – high pitch
- ☐ decreased hearing
- ☐ ear infections

Pregancies: Living _____ Ectopic_____ Miscarriages _____ Abortions_____

Heart

- ☐ High blood pressure
- ☐ Low Blood pressure
- ☐ Palpitations
- ☐ Irregular heart beat
- ☐ Chest pain or pressure
- ☐ Jaw, neck, shoulder or arm pain
- ☐ Nausea
- ☐ Swollen hands or feet
- ☐ Blood clotting disorders
- ☐ Phlebitis
- ☐ Poor memory
- ☐ Crave bitter foods

Stomach and Large Intestine

- ☐ Fevers
- ☐ Frequent or strong thirst
- ☐ Tend to feel warmer than others
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Prefer cold food and drink
- ☐ Chills
- ☐ Cold hands/feet
- ☐ Tend to feel colder than others
- ☐ Cold sweats
- ☐ Prefer warm food and drink
- ☐ Headache
- ☐ Neck stiffness
- ☐ Concussion
- ☐ Enlarged lymph

Infectious Diseases

- ☐ HIV
- ☐ TB
- ☐ Chicken pox
- ☐ Meningitis
- ☐ Hepatitis
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Syphilis
- ☐ Genital warts
- ☐ Herpes oral/genital
- ☐ HPV
- ☐ Covid 19

Other past or current infectious diseases _____

Other current symptoms / motivations for coming for acupuncture: _____

_____

_____

Please describes your health priorities in order of importance:

_____

_____

_____

_____

patient: _____

Patient Information
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Habits – Please check any habits which apply to you now or in the past

Coffee	__ yes __ no	# per day _____	age started _____	age quit _____
Tobacco	__ yes __ no	# per day _____	age started _____	age quit _____
Marijuana	__ yes __ no	# per day _____	age started _____	age quit _____
Alcohol	__ yes __ no	# per day _____	age started _____	age quit _____
Sugar	__ yes __ no	# per day _____	age started _____	age quit _____
Prescription drugs	__ yes __ no	# per day _____	age started _____	age quit _____

Other relevant habits: _____

Major Hospitalizations Please list any hospitalization or surgeries you have undergone

Year	Operation or Illness	Name of Hospital	City and State

Medicines, Herbs, Supplements that you are currently taking or took very recently

___ aspirin
___ ibuprofen
___ acetaminophen (Tylenol)
___ oral contraceptives
___ antacids
___ fiber/laxatives
___ diet pills
___ allergy medication
___ blood thinners
___ blood pressure pills
___ insulin
___ antidepressants
___ sleeping pills
___ tranquilizers

Other Medications -- please list:

Western Drugs	Herbs	Vitamins and Supplements

Medication Allergies _____

_____

Food Allergies or sensitivities _____

_____

Please describe any restricted diet(s) you follow

_____

_____

patient: _____