Alexandra Clinton, D.O.M, A.P

General Information

Today's Date_______________
Name__________________________ Age______ Date of Birth_____________
Address________________________ City____________ State_________ Zip_______
Phone #'s: Home_________________ Cell_________________ Work______________
Sex: M F Marital Status______ Email
Address____________________________
Employer_________________________ Occupation____________________________
Emergency Contact_________________ Phone_______________ Relation__________

Health Insurance Information

Primary Insurance________________ Policy Holder's Name____________ DOB_____
Policy Holder's Relation to Patient__________ Policy Holder's Employer____________

Accident Information

Condition due to an Auto Injury? Date of Accident__________ Place (city/state)______
Have you reported the accident to your insurance company? Yes No Claim #_________

Current Complaint

Please list the reason you are here____
How long have you had these symptoms_______________________________________
Are they ___Improving ___Worsening____ About the same
How did this condition start___________________ Is it Mild Moderate Severe
What makes it worse____________________ What makes it better_________________
Is the pain __Dull/Achy __Sore/Stiff __Sharp/Stabbing __Numb/Tingly __Shooting
Is the pain worse __In the morning __As the day wears on __At night __Fairly steady
On a scale of 0-5, rate how your pain affects the following: ____Lifting ____Walking
____Sitting ____Standing ____Sleeping ____Driving/Traveling ____Working

Current Health

Name, address and phone of your family doctor__________________________________
Are you currently under a doctor's care for an illness or injury? If so please list their
Name and address__________________________ Nature of
illness/injury____________
If you are currently taking prescription or non-prescription medications, please list them
Medication __________ Dose __________ Medication __________ Dose ________
Medication __________ Dose __________ Medication __________ Dose ________

Please list any medications that you are allergic to ______________________________
You height and weight ______________What is your usual blood pressure _____/_____

Health History

If you have ever had any operations, surgeries or medical procedures, please list them:
Date __________ Procedure ____________ Date _________ Procedure___________
Date __________ Procedure ____________ Date _________ Procedure___________

If you have ever in the past had any serious illness or injuries, please list them:
Date __________ Condition ____________ Date __________ Condition _________
Date __________ Condition ____________ Date __________ Condition _________

Please list any significant family illnesses _____________________________________
Do you have a Pacemaker? Yes No
Do you smoke? Yes No __ pack/day/week Do you drink alcohol? Yes No
Have you ever had Acupuncture? No Yes If yes, last date of treatment _____________
By whom? ______________ Similar/Different condition? _________ Results _______
What are your overall expectations from your treatment with Alexandra? ____________
____

I, the undersigned, hereby give my consent for Alexandra Clinton, D.O.M, A.P to examine and treat my condition as she deems appropriate through the use of Acupuncture and/or additional modalities.

Patient's signature ____
(parent/guardian signature if patient is under 18 years of age)