Kristen Swegles LAc. | *411 E Canon Perdido Suite 18*
kristenswegles@gmail.com kristenswegles.com | 831 359 7779

New Patient Information

Name _____ Today's Date _____

Street Address _____ Apt. _____

City _____ State _____ Zip _____

Preferred Phone _____ Email _____

Birth Date (include year) _____ Age _____ Gender _____

Occupation _____ Employer _____

Referred by _____

Emergency Contact: Name _____ Phone _____

Fees:

It is our policy that you pay the entire session fee or co-pay at the time of each session. We will provide a minimum of one month's notice of any changes to our fees.

Insurance Company _____

Insurance Company Phone Number (Provider Line) _____

ID # _____

Please bring a photocopy of your insurance card (front and back) **or** bring your card to your first appointment so we can make a copy at the clinic.

Cancellation Policy:

If you need to change or cancel your appointment please do so with a minimum of 24 hours notice. Failure to do so will result in being charged the equivalent of the cash rate of the missed appointment to your account.

☐ **I understand the cancellation policy.**

Signature:_____ **Date:** _____/_____/_____

(continued onto next pages)

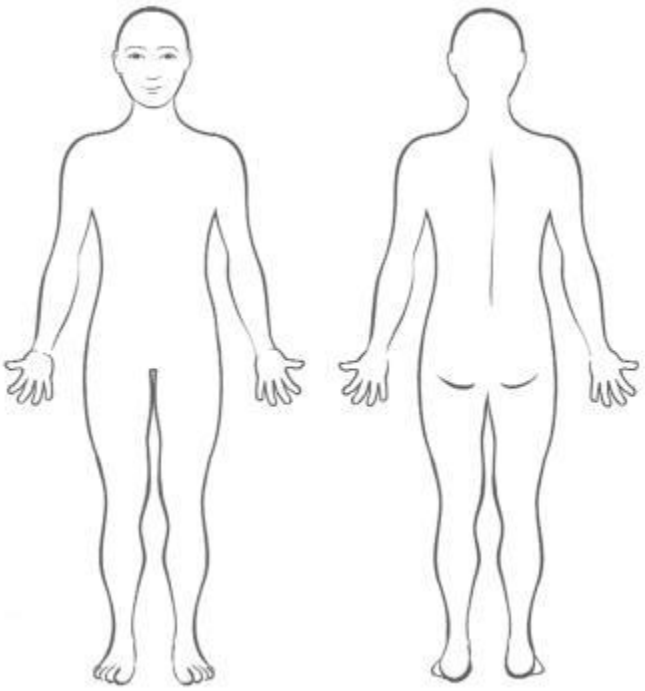
Health History

Have you had acupuncture before? _____ If so, for what reason? _____
Main issue(s) you are seeking treatment for: _____

_____

Diagnosis from a medical professional (if applicable): _____

Please mark any areas of pain or discomfort:



Please check any symptoms that you have experienced in the past or currently experience:

General

	past	current		past	current
sweating easily during the day	☐	☐	fatigue	☐	☐
night sweating	☐	☐	fevers	☐	☐
bleed or bruise easily	☐	☐	chills	☐	☐
change in appetite	☐	☐	weight loss/gain	☐	☐
dizziness/vertigo	☐	☐	poor sleep	☐	☐

Skin & Hair

	past	current		past	current
rashes/hives	☐	☐	psoriasis	☐	☐
eczema	☐	☐	loss of hair	☐	☐
acne	☐	☐			

Head, Ears, Eyes, Nose & Throat

	past	current		past	current
earaches/pressure in the ears	☐	☐	headaches/migraines	☐	☐
ringing in the ears	☐	☐	sinus pressure	☐	☐
hearing loss	☐	☐	nose bleeds	☐	☐
eye floaters	☐	☐	dizziness/vertigo	☐	☐
itchy eyes	☐	☐	teeth/jaw clenching	☐	☐
blurry vision	☐	☐			

Cardiovascular/Circulatory

	past	current		past	current
chest pain	☐	☐	swelling/edema	☐	☐
fainting	☐	☐	high blood pressure	☐	☐
lightheadedness	☐	☐	low blood pressure	☐	☐
cold hands & feet	☐	☐			

Respiratory

	past	current		past	current
pain on inhaling	☐	☐	sneezing	☐	☐
chest tightness	☐	☐	seasonal/other allergies	☐	☐
cough	☐	☐	phlegm production	☐	☐
asthma	☐	☐			

Genito-Urinary

	past	current		past	current
difficulty urinating	☐	☐	urgent/frequent urination	☐	☐
blood in urine	☐	☐	sores on genitals	☐	☐
pain upon urination	☐	☐	genital pain	☐	☐

Neurological/Psychological

	past	current		past	current
anxiety	☐	☐	poor memory	☐	☐
depression	☐	☐	quick temper	☐	☐

	past	current		past	current
loss of balance/coordination	☐	☐	easily susceptible to stress	☐	☐
areas of numbness/paralysis	☐	☐			

Digestive

	past	current		past	current
heartburn	☐	☐	gas	☐	☐
belching	☐	☐	diarrhea	☐	☐
bloating	☐	☐	constipation	☐	☐
nausea	☐	☐	abdominal pain/cramps	☐	☐
vomiting	☐	☐	mucus in stool	☐	☐
chronic bad breath	☐	☐	blood in stool	☐	☐
sores on lips/tongue	☐	☐	hemorrhoids	☐	☐

For Women Only:

	past	current		past	current
irregular periods	☐	☐	breast pain	☐	☐
painful periods	☐	☐	vaginal discharge	☐	☐
bleeding between periods	☐	☐	vaginal sores	☐	☐
period clots	☐	☐	hot flashes	☐	☐
menstrual cramping	☐	☐	night sweating	☐	☐

age of first menses _____ duration of typical period _____

duration of typical cycle _____ date of last PAP _____

# of pregnancies _____ # of live births (+ years) _____

# of miscarriages _____ # of abortions _____

Have you been through menopause? Age? _____

Have you ever taken birth control pills? When and for how long? _____

Other premenstrual & menstrual symptoms (bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.)

_____

_____

_____

For Men Only:

	past	current		past	current
erectile dysfunction/impotence	☐	☐	ejaculatory pain	☐	☐
varicocele	☐	☐	BPH	☐	☐

Lifestyle

Current medications/herbs/supplements:

_____

_____

_____

Do you follow any certain diet or way of eating? (vegetarian, gluten-free, paleo, etc.)

_____

_____

_____

Current exercise routine:

_____

_____

_____

Do you use tobacco? If so, how often?

_____

_____

Do you drink alcohol? If so, how many drinks/week?

_____

_____

Are you currently taking any of the following medications?

(circle if yes and indicate how often)

Advil/Motrin/Ibuprofen	Aleve/Naproxen	Bayer/Aspirin
Celebrex/Celecoxib	Prednisone/Prednisolone	

Are you currently taking any other pain medications? If yes, list name and amounts per day:

_____

_____

_____

Allergies (medications/foods/chemicals/etc.):

_____

_____

_____

Have you ever had a seizure? If yes, indicate date of last: _____

Please circle any significant illnesses and indicate date:

Cancer	Hepatitis	Diabetes
High blood pressure	Epilepsy	Heart Attack
Stroke	Ulcer Disease	Liver Disease
Colon Polyps	Other _____	

Please list any major surgeries/hospitalizations and approximate dates:

_____

_____

_____

Family Medical History

□ Cancer □ Seizures □ High blood pressure □ Stroke □ Diabetes

□ Heart Attack □ Hepatitis □ Asthma □ Other _____

Please list any other relevant information or issues you would like to discuss:

Thank you for taking the time to fill out these forms. Please let us know if you have any questions or concerns.