Dr. Heather Bird, DAOM, L.Ac. *www.healingbird.com*

Patient Name_____ Birth date ____/____/____ M F circle one
Address_____ City_____ State_____ Zip_____
Phone (Home)(___)_____ (Work)(___)_____ (Cell)(___)_____
E-mail _____Referred by_____
Employer_____ Occupation_____
Reason for seeking treatment _____
_____ ***Date symptom(s) started*** _____
Do you have medical insurance that covers acupuncture? Yes_____ No_____
If yes, please provide insurance card so that we may verify coverage.

Circle area(s) of current pain: Head, Neck, Jaw, Shoulder, Arm, Elbow, Wrist, Hand, Upper Back, Lower Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other_____
Circle your pain level: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

How often are your symptoms present? Constantly__ Frequently__ Intermittently__ Occasionally___
Describe your current health condition? Good___ Fair___ Poor___ Chronically Ill___
Can you perform all your daily activities? Yes, all activities___ Some activities___ Not at all___
Are you currently under the care of a physician? No____ Yes____
What treatments, if any, have you received for the condition you've come to us for? (Surgery, medications, chiropractic, etc.)_____
_____

Please check the appropriate boxes:

Past / Present
____ ____ Alcohol/tobacco/drug Dependence
____ ____ Abnormal menstruation
____ ____ Allergies
____ ____ Angina
____ ____ Arthritis/rheumatoid arthritis
____ ____ Artificial joints
____ ____ Asthma
____ ____ Blood disorder
____ ____ Breast lumps
____ ____ Cancer/tumor
____ ____ Convulsions/seizures
____ ____ Diabetes
____ ____ Diarrhea/constipation
____ ____ Excessive thirst
____ ____ Fainting or dizziness
____ ____ Rapid weight gain/loss

Past / Present
____ ____ Frequent urination
____ ____ Headache
____ ____ Heart attack
____ ____ Heartburn/Indigestion
____ ____ High blood pressure
____ ____ Hospitalizations
____ ____ Surgical procedures
_____
____ ____ Kidney disease
____ ____ Liver problems
____ ____ Pacemaker
____ ____ Painful menstruation
____ ____ Palpitation/arrhythmia
____ ____ Peptic ulcer
____ ____ PMS
____ ____ Pregnancy
If pregnant, how many months along
_____

Past / Present
____ ____ Sinusitis
____ ____ Stroke
____ ____ Thyroid
____ ____ Medications
_____
_____
_____
____ ____ Other: ____
_____

If a family member has had any of the following circle all that apply:

Arthritis Lupus Cancer
Heart Disease Mental
Hypertension

Patient Signature: _____ Date: _____