Linda Gross, L.Ac., MTCM
New Patient Form

PATIENT INFORMATION

Patient Name: _____ Date: _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____

Cell Phone: (_____) _____

E-mail: _____

Sex: ☐ M ☐ F Date of Birth: _____/_____/_____ Age: _____

Social Security No. : _____-_____-_____

Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Separated

☐ Divorced ☐ Minor

Occupation: _____

Patient Employer: _____

Employer Address: _____

Employer Phone: (_____) _____

Spouse's Name: _____

Spouse's Date of Birth: _____/_____/_____

Spouse's Social Security No. : _____-_____-_____

Spouse's Employer: _____

Whom may we thank for referring you? _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Primary Phone: (_____) _____

Secondary Phone: (_____) _____

Patient Name: _____

INSURANCE INFORMATION

Insurance Provider: _____

Group No.: _____ Subscriber No.: _____

Subscriber Name: _____

Subscriber's Date of Birth: _____/_____/_____

Subscriber's Social Security No. : _____-_____-_____

Subscriber Relationship to Patient: _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

_____
(Name of Insurance Company)

and assign directly to Linda Gross, L.Ac. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named healthcare professional may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
(Patient/Guardian Signature)

_____
(Patient/Guardian Name)

Date: _____/_____/_____ Relationship to Patient: _____

Patient Name: _____

PATIENT HEALTH HISTORY

Check (☑) the symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Fever
- ☐ Anxiety
- ☐ Forgetfulness
- ☐ Headache
- ☐ Problems sleeping
- ☐ Weight loss
- ☐ Numbness
- ☐ Tingling

MUSCLE/JOINT/BONE

Pain, weakness, or numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Acid reflux
- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of the ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in the ears
- ☐ Sinus problems
- ☐ Vision – Flashes/Halos

SKIN
- ☐ Bruise easily
- ☐ Dry skin
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Check (☑) the conditions you currently have or have had in the past.

- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Describe serious illnesses or operations:

Patient Name: _____

HEALTH HABITS

Check (☑) what you use and how much:

☐ Caffeine _____
☐ Tobacco _____
☐ Alcohol _____
☐ Street Drugs _____

MEDICATIONS AND ALLERGIES

What medications are you currently taking?

Medication:	**Dose:**	**Frequency:**

Allergies to medications: _____

Allergies to substances: _____

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my acupuncturist if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Guardian, or Personal Representative | Date

_____ _____
Print name of Patient, Guardian, or Personal Representative | Relationship to Patient

_____ _____
Reviewed By | Date