acupuncture LIFEOLOGY

Daisy Dong LAc. CMD

1325 S Colorado Blvd. Suite B 012
Denver, Colorado 80222
aculifeology@gmail.com
303.949.8428D

Traditional Chinese Medicine

Acupuncture, Chinese Herbology & Tui-Na,

1. About you Today's Date _____

You are (name): _____ Male ☐ Female ☐

Date of Birth: _____ Height _____ Weight _____

Home address: _____(Street)

(City) _____ (State) _____ (Zip) _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Windowed ☐ Partnership

Telephone: (home) _____ (Mobile) _____

(Work) _____ (email) _____

Emergency contact person's name (print clearly): _____

Emergency contact Number: _____(Tel) Relationship to you _____

Work Status: ☐ Full time ☐ Part time ☐ Homemaker ☐ Self employed ☐ Unemployed ☐ Retired

Occupation: _____Company: _____

2. About your today's visit (check)

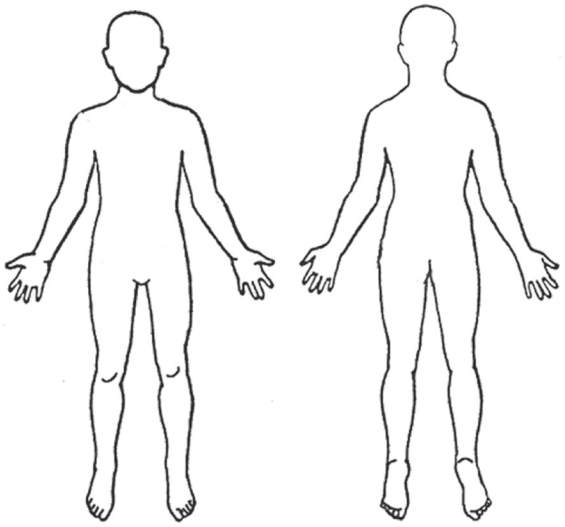
a. Injury: ☐ Auto ☐ Work ☐ Sports ☐ Fall ☐ Other

b. Illness: ☐ 2 wks ☐ 6 mo ☐ 1 years ☐ 10 years

c. Pain: ☐ Acute ☐ Chronic

d. Pain scale at this moment 0-10: _____ Describe Pain_____

Circle or X where you feel pain:



3. About your payment information

a. Self pay: (YES) _____(NO) _____

b. Please sent my bill to: _____

i. Auto insurance _____ Policy #_____

ii. Health Insurance _____ Policy #_____

iii. Worker's Compensation _____ Case # _____

iv. Military Tri-care: _____

v. Other: _____

c. Detail information of your billing party

Insurance Name: _____ Insurance Phone: _____

Insurance Address: _____

Subscriber's Name _____

Subscriber's SS# _____ Subscriber's DOB: _____

Subscriber's Employer _____ Groups # _____

Name of Attorney: _____ Attorney/physician's # _____

Date Retained: _____ Co-pay amount: _____

4. About your lifestyle

a. Caffeine ☐ Yes ☐ No

b. Alcohol ☐ Yes ☐ No

c. Tobacco ☐ Yes ☐ No

d. Marijuana ☐ Yes ☐ No

e. Vegetarian diet ☐ Yes ☐ No

f. Carnivore diet ☐ Yes ☐ No

g. Sugar Craving ☐ Yes ☐ No

h. Regularly exercise ☐ Yes ☐ No such as _____

i. Stress from work, family, relationship or others ☐ Yes ☐ No

5. Are you taking medication? ☐ Yes ☐ No (If yes, what are you currently taking?)

a. Rx: _____

b. Supplements _____

c. Herbals: _____

d. Others _____

6. Allergies

a. Drug allergy: _____

b. Food allergy: _____

c. Environmental allergy: _____

7. If you are female, please answer these questions:

a. Are you currently pregnant _____ (weeks)

b. Your last menses started on _____

c. # days of your menstrual cycles: _____

d. Any PMS or cramp pre or during menstruation? ☐ Yes ☐ No

e. Any miscarriage? ☐ Yes ☐ No

f. Are you taking contraceptive pills pills? ☐ Yes ☐ No

g. How many children did you give birth to? _____

h. Are you having menopausal symptoms (hot flashes/night sweats)? ❑ Yes ❑ No

8. About your present medical history

a. Regarding your pain:

i. Frequency: _____

ii. Locations: _____

iii. Nature: ☐ sharp ☐ dull ache ☐ cramping ☐ sore ☐ tightness, or _____

b. Your illness/pain is formally diagnosed with _____

c. Surgeries that related to this visit

i. Where: _____

ii. When: _____

iii. Result: _____

d. Treatments that you have tried for this illness/pain:

i. Surgery ☐ Yes ☐ No

ii. Physical therapy ☐ Yes ☐ No

iii. Chiropractics ☐ Yes ☐ No

iv. Massage therapy ☐ Yes ☐ No

v. Prescription ☐ Yes ☐ No

vi. Psychotherapy ☐ Yes ☐ No

vii. Acupuncture ☐ Yes ☐ No

viii. Herbal medicine ☐ Yes ☐ No

ix. Other: _____

9. Other medical history: _____

i. Heart disease _____

ii. Diabetes _____

iii. Hypertension _____

iv. Cholesterol _____

v. Thyroid disorder _____

vi. Cancer _____

vii. Bleeding disorder _____

viii. Organ transplant _____

10. Informed consent

Patient's signature: _____ Date: _____

Guardian's signature (if patient is a minor): _____ Date: _____