JORDAN JACOBS, L.Ac, MAcOM. LE

512-337-2588 | jordan@ctw.care

18700 FM 1431, Ste. F • Jonestown, TX 78645

Patient Name:

MEDICATIONS

	Please list or provide a current copy of all medications, supplements, vitamins, herbs, etc, along with dose and frequency consumed:					
MEDICATION NAME	DOSE/MG	RX (DAILY, ET)	CONDITION PRESCRIBED FOR	REFILLS	MO//YEAR PRESCRIBED	RX CHANGED AND DATE

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Personal Information & Health Survey

Important: The information in this form will help your practitioner give you the best and most comprehensive care possible. It is important for you to complete this document as thoroughly as possible. Even though some of the questions may seem unrelated to your complaint, they give us a full picture to contribute to TCM diagnosis and treatment of the root cause of your condition. All information provided is strictly confidential.

Name				Today's Date	
Street Address					Apt
City				State	Zip
Preferred Phone			Email		
Birth Date (w Year)			Age		Gender
Marital Status	Single	Married	Separated	Divorced	Widowed
Occupation			Employer		
How did you hear about this business?					
Or, whom can I thank for your referral?					
Name of Guardian (if under 18)				Relationship	
Emergency Contact:	Name		Phone Number		Relationship

Cancellation Policy

We understand things out of our control happen in life. We politely ask for 24 hours notice if you cannot make your scheduled appointment. Otherwise we charge a flat fee of $50 for the appointment to the credit card on file. If you forget or forgo your appointment you will be considered a 'no-show' and will be charged a flat fee of $50.

I understand the cancellation policy and agree to the terms

Signature _____ Date _____

Fees:

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

Please answer YES or NO to the following statements:

I have been evaluated by a physician or a dentist for the condition being treated within 12 months prior to having acupuncture performed.	YES	NO
I have received a referral from a Chiropractor within the last 30 days for Acupuncture.	YES	NO

I recognize that I should be evaluated by a physician for the condition being treated by the acupuncturist. If after 60 days or 20 treatments, whichever comes first, if no substantial improvement occurs in the condition being treated. I understand that the acupuncturist is required to refer me to a physician.

I have read, or have had read to me, and understand all of the above information and guarantee this form was completed correctly and to the best of my knowledge.

Patient Signature or Signature of Patient's Guardian _____

Date signed _____

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CARDIOVASCULAR/CIRCULATORY	PAST	CURRENT		PAST	CURRENT	
chest pain	☐	☐	swelling/edema	☐	☐	
fainting	☐	☐	high blood pressure	☐	☐	
lightheadedness	☐	☐	low blood pressure	☐	☐	
cold hands & feet	☐	☐	heart palpitations	☐	☐	

RESPIRATORY	PAST	CURRENT		PAST	CURRENT	
pain on inhalation	☐	☐	sneezing	☐	☐	
chest tightness	☐	☐	seasonal allergies	☐	☐	
cough	☐	☐	phlegm production	☐	☐	color?
asthma inhaler: y n	☐	☐	shortness of breath	☐	☐	
copd	☐	☐	sleep apnea	☐	☐	cpap?
sinus congestion	☐	☐				

GENITO-URINARY	PAST	CURRENT		PAST	CURRENT
difficulty urinating	☐	☐	urgency in urination	☐	☐
blood in urine	☐	☐	UTIs	☐	☐
pain upon urination	☐	☐	yeast infections	☐	☐
kidney stones	☐	☐	STDs	☐	☐
frequent urination	☐	☐	incontinence	☐	☐

NEUROLOGICAL/PSYCHOLOGICAL	PAST	CURRENT		PAST	CURRENT
anxiety	☐	☐	poor memory	☐	☐
depression	☐	☐	foggy mind	☐	☐
loss of balance/coordination	☐	☐	quick temper	☐	☐
areas of numbness/paralysis	☐	☐	easily stressed	☐	☐
tingling in hands/feet	☐	☐			

DIGESTIVE	PAST	CURRENT		PAST	CURRENT
heartburn	☐	☐	gas	☐	☐
belching	☐	☐	diarrhea	☐	☐
bloating	☐	☐	constipation	☐	☐
nausea	☐	☐	alternating diar/const	☐	☐
vomiting	☐	☐	abdominal pain/cramps	☐	☐
chronic bad breath	☐	☐	mucus in stool	☐	☐
sores on lips/tongue/gums	☐	☐	blood in stool	☐	☐
GERD	☐	☐	hemorrhoids	☐	☐
gastric bypass	☐	☐	IBS	☐	☐
poor appetite	☐	☐	excessive hunger	☐	☐

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FOR WOMEN ONLY	PAST	CURRENT		PAST	CURRENT
irregular periods	☐	☐	vaginal discharge	☐	☐
painful periods	☐	☐	vaginal sores	☐	☐
bleeding between periods	☐	☐	vaginal dryness	☐	☐
period clots	☐	☐	hot flashes	☐	☐
menstrual cramping	☐	☐	night sweating	☐	☐

age of first menses duration of typical period duration of cycle

# of pregnancies # of miscarriages

been through menopause? Y N if yes, age?

have you ever taken birth control pills? Y N if yes, when, and for how long? current birth control?

other premenstrual & menstrual symptoms: (circle): bloating breast tenderness irritability mood swings fatigue loose stools acne

FOR MEN ONLY	PAST	CURRENT		PAST	CURRENT
erectile dysfunction/impotence	☐	☐	ejaculatory pain	☐	☐
varicocele	☐	☐	BPH	☐	☐
interrupted urination	☐	☐	urinating at night	☐	☐
hernia	☐	☐			

ENERGY	PAST	CURRENT		PAST	CURRENT
sudden energy drop: time of day:	☐	☐	dependence on caffeine	☐	☐
energy drop after eating	☐	☐	wired feeling	☐	☐
fatigue	☐	☐	body/limbs feel heavy	☐	☐
hard to concentrate	☐	☐	body/limbs feel weak	☐	☐

SLEEP	PAST	CURRENT		PAST	CURRENT
average # hours per night			not rested on waking	☐	☐
difficulty falling asleep	☐	☐	wake to urinate	☐	☐
waking __ x per night @ __ am/pm	☐	☐	disturbing dreams	☐	☐
restless sleep	☐	☐	restless leg syndrome	☐	☐

EMOTIONS	PAST	CURRENT		PAST	CURRENT
anger	☐	☐	grief	☐	☐
irritability	☐	☐	depression	☐	☐
worry	☐	☐	joy	☐	☐
obsessive thinking	☐	☐	fear	☐	☐
timid/shy	☐	☐	indecision	☐	☐
sadness	☐	☐			

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LIFESTYLE

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

Current exercise level: None 1 - 2 x week Daily

Type:

Do you smoke? Y N If Yes, what, how often?

Do you drink alcohol? Y N If Yes, how many drinks per week?

ALLERGIES (FOOD, CHEMICALS, MEDICATIONS, OTHER)

Have you ever had a seizure? Y N Date of last event?

Please circle significant illnesses and indicate date:

cancer	hepatitis	diabetes	breaks or sprains
stroke	epilepsy	heart attack	other:
colon polyps	ulcer disase	liver disease	

List major surgeries/hospitalizations and approximate dates:

Family Medical History: Circle any that apply:

cancer	stroke	diabetes	asthma
seizures	high blood pressure	hepatitis	other

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

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NAME Date

Health History

Have you had acupuncture before? Yes No If so, for what reason? _____

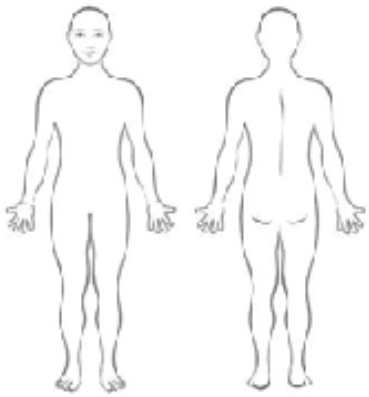
Main issue(s) you are seeking treatment for today: _____

_____

_____

Diagnosis from a medical professional (if applicable): _____

Please mark 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	☐	☐	alopecia	☐	☐
skin changes	☐	☐	melasma	☐	☐
dryness	☐	☐	itching	☐	☐
oiliness	☐	☐			

HEAD, EARS, EYES, NOSE, THROAT	PAST	CURRENT		PAST	CURRENT
earaches/pressure in the ears	☐	☐	headache/migraine	☐	☐
ringing in the ears	☐	☐	sinus pressure	☐	☐
hearing loss	☐	☐	nose bleeds	☐	☐
eye floaters	☐	☐	dizziness/vertigo	☐	☐
itchy eyes	☐	☐	teeth/jaw clenching	☐	☐
blurry eyes	☐	☐	sore throat	☐	☐