Rutherford Family Acupuncture

108 E 1st St, Rutherfordton, NC
RutherfordFamilyAcupuncture.com
(828) 375-0076

MEDICAL HISTORY

THIS INFORMATION IS CONFIDENTIAL.

Name ______________________________ **Date** ____________

Street Address ______________________________

City ______________________________ **State/Zip**______________________________

Home Phone____________________ **Cell Phone**____________________ Preferred: □ Home □ Cell

May we leave confidential voicemails at these numbers? □ Yes □ No

E-mail ______________________________

Age __________ **Date of Birth** ________________ **Gender**_________

Marital Status: □ Married □ Never Married □ Widowed □ Divorced or Separated

Occupation:______________________________ **Retired:** ____ **Disabled:** ____**Unemployed:** ____

Primary Care Physician: ______________________________

How did you hear about us?: ______________________________

Emergency Contact:______________________________ **Emergency Contact Relation to you:** _____________

Emergency Contact telephone:____________________ **E-mail** ______________________________

Have you ever had a massage before? □ Yes □ No **If yes, when was your last massage?** ____________________

Main Problem you would like us to help you with:______________________________

____

How long ago did this problem begin? *Please be specific*: ______________________________

____

How does this problem affect your daily life? ______________________________

____

Have you been given a diagnosis for this problem? If so, what diagnosis and by whom?

____

What other kinds of treatment have you tried? □ Western Medicine □ Acupuncture □ Herbs

□ Massage □ Physical Therapy □ Chiropractic □ Other:___________________________

How confident are you that massage will be able to resolve the symptoms of your main complaint?

□ Not confident □ Slightly confident □ Moderately confident □ Confident □ Very confident

How committed are you to resolving this problem? (1=least, 10=most) ___________________________

Secondary Complaints you would like us to help you with:

1) ____

2) ____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): ____________________

____

Hospitalizations/Surgeries (including dates):____

____

S**ignificant Trauma (auto accidents, falls, etc.**): ____

____

Allergies (drugs, chemicals, metals, foods): ____

____

Do you have a pacemaker, ICD, artificial joint, or other medical implant? □ Yes □ No

If yes, please elaborate:____

Please note location of all scars and tattoos (e.g., operation or injury scars, <u>even minor ones)</u> _______________

____

<u>FOR WOMEN:</u>

Are you pregnant? □ Yes □ No **Is it possible that you are pregnant?** □ Yes □ No **Number of pregnancies:** ____

Live births: _____ Miscarriages: _____ Stillbirths: _____ Abortions: _____ Premature births: _____

Please indicate if any of the following apply to you:

Cancer
Headaches/Migraines
Arthritis
Diabetes
High/Low Blood Pressure
Neuropathy
Fibromyalgia
Stroke
Heart Attack
Kidney Dysfunction
Blood Clots
Numbness
Sprains or Strain

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.

Signature ____ **Date** ____________________