

New Patient Intake Form

Today's Date _____ / _____ / _____

Name	SS#	Birthdate	/	/	/
Address	Marital Status	Age	Ht	Wt	
	<input type="checkbox"/> M <input type="checkbox"/> F				
City, State, Zip	Work Phone	Occupation			
Home Phone					
Emergency Contact Name & Phone					
Referred by					
Reason for visit today	Have you had acupuncture before?	Chinese herbal medicine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
How long have you had this condition?					
Is it getting worse?	Does it bother your:	<input type="checkbox"/> Sleep	<input type="checkbox"/> Work	<input type="checkbox"/> Other (what?)	
What seemed to be the initial cause?					
What seems to make it better?					
What seems to make it worse?					
Are you under the care of a physician now?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, for what?			
Who is your physician?		Physician's Phone			
Other concurrent therapies					

Health Insurance Info:

Insurance Co. Name	Policy #
Address	Phone
City, State, Zip	

Medicare Info:

Insurance Co. Name	Policy #
Address	Phone
City, State, Zip	

Family Medical History

<input type="checkbox"/> Allergies	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures
_____	<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke
_____	<input type="checkbox"/> Alcoholism	_____	<input type="checkbox"/> High Blood Pressure	

Your Past Medical History

Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.)

<input type="checkbox"/> AIDs/HIV	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Surgery (list)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Mumps	_____	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Allergies	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pacemaker	_____	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Goiter	<input type="checkbox"/> Pleurisy	_____	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Gout	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Thyroid Disorders	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Polio	<input type="checkbox"/> Major Trauma	<input type="checkbox"/> Other (Specify)
<input type="checkbox"/> Birth Trauma (your own birth)	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic Fever	(Car, fall, etc--list)	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes	<input type="checkbox"/> Scarlet Fever	_____	_____
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures	_____	_____
	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke	_____	_____

Your Diet

Appetite <input type="checkbox"/> Low <input type="checkbox"/> High	<input type="checkbox"/> Coffee <input type="checkbox"/> Soft Drinks	<input type="checkbox"/> Artificial Sweetener	<input type="checkbox"/> Sugar <input type="checkbox"/> Salty Food	Thirst for water: # glasses per day: _____
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Average Daily Menu

Morning	Snack	Noon	Snack	Evening	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Pharmaceuticals taken in last 2 months: _____
Vitamins/supplements taken in last 2 months: _____

Peak Performance Holistic Therapies
4732 Point Loma Ave Ste. D
San Diego, Ca 92107

Danae Koolen L.Ac. • Jill Suess L.Ac.

Description of services	Fee
Initial Acupuncture Consultation & Treatment	\$90
Acupuncture Follow-up Treatment	\$70
Massage 90 min.	\$90
Massage 1 Hour	\$70
No Show/Late Cancellation Fee (24 hour notice required)	Price of service

- Payment in full is required at the time of service unless other arrangements have been made in advance.
- We will provide you with an itemized receipt and instructions for submitting claims to your insurance for reimbursement. Your insurance coverage is a contract between you and your insurer. You alone are responsible for verifying coverage and benefits. We make no guarantee or promise that your insurance will pay for treatment.
- Cash, Check, MasterCard & Visa accepted for payment.
- Fees may change without notice at any time.
- We have the right to refuse service to anyone.

I have read and understand the above fees and payment policies. I accept full responsibility for timely payment of all services and supplies received at Peak Performance Holistic Therapies.

Signature of patient (or guardian if under 18 years of age)

Date