Abby Rappoport L.Ac., CMQ

www.abbyrapp.com | (805)628-2142

New Patient Health History Form

Patient Information

First Name: _____ Middle: _____ Last:_____

E-Mail: _____ Today's Date: _____/_____/_____

Phone #: (home)_____ (cell) _____ (work) _____

Address: _____ City: _____State: _____ Zip: _____

Social Security#: _____ Birthday: _____/_____/_____

Gender: _____ Height: _____ Weight:_____ Marital Status: _____

Occupation: _____ Employer: _____

Will you be relying on this medical practice as your primary health-care provider? Y N

Emergency Contact

Name: _____ Relationship: _____

Phone#: _____ Alternate contact info: _____

***For Minors**

Parent(s) Names(s): _____ _____

Alternate Parent Contact Information: _____

Insurance Information

To keep the cost of treatment low, and so that our focus is always on excellent patient care, we do not bill insurance directly. If your insurance plan includes an acupuncture benefit, we can provide you with a coded invoice that you may submit to your insurance company for reimbursement.

☐ Check here if you would like to be provided with a super bill to self-submit to your insurance.

☐ If our policy changes and we do start to bill insurance directly, check here to be notified.

Current Complaints

Please identify the health concerns that bring you to this medical office today:

How long have you been experiencing this/these issue(s)?

Have you had acupuncture or used herbal medicine before?
When and where?

When and where did you last receive Medical care?

For what condition?

How did you hear about us?

General Medical History

Please list any known allergies or hypersensitivities to specific foods, drugs, or medications (please include reaction):

Please list any medications (prescribed or over-the-counter), vitamins, supplements, or herbs you are currently taking:

Please list any medical diagnoses you have been given by a medical professional:

Please list any history of hospitalizations or surgeries:

_____ Date: _____

_____ Date: _____

_____ Date: _____

*continue on the blank side of this form if necessary

Women's Health

Age of First Menses: _____

Dates of most recent 3 Menses: _____ _____ _____

Is there <u>any chance</u> you may be pregnant? Y N if so, how many weeks/months? _____

Have you experienced any of the following (please circle):

Irregular Cycles	Abnormal Discharge	Menopausal Symptoms	Breast Lumps
PMS	Heavy/Scanty Flow	Difficulty conceiving	

Lifestyle

	None	Light	Moderate	Heavy
Tobacco	○	○	○	○
Alcohol	○	○	○	○
Coffee	○	○	○	○
Soda/Cola	○	○	○	○
Recreational Drugs	○	○	○	○

Average Breakfast:

Average Lunch:

Average Dinner:

Snacks:

Do you have any dietary restrictions (i.e. vegetarian, kosher, etc…)?

Do you exercise? Y N What Type(s)?

How often?

Is there anything else you would like to share with us about your medical history or lifestyle?

Office Policies and Financial Agreement

Please Read and initial the following:

____ Payment for all services and dispensary items are due at the time of service.

____ We have a **24-hour cancellation policy**. You will be charged the full price of services for any missed or late-cancelled appointments.

____ I give permission for Abby Rappoport, or a staff member to contact me via telephone or email to leave a message that may contain appointment or medical information if I am not available.

I have read and understand the office policies of Abby Rappoport, LAc., and have answered all of the above questions truthfully and to the best of my knowledge.

_____ _____

Patient Signature (or legal guardian) Date