

# ACUPUNCTURE WELLNESS CLINIC

Lady Melody J Clancy, M. Ac., D.O.M., A.P. ~ ~ 941-586-4064

## Personal Information

Date

Patient Name:	Last	First	Middle
Address:			Zip Code
Telephone:	Home	Cell	Work
Email:	Fax:		
Date of Birth:	Age		Gender
Emergency Contact:	Tel:		Relationship
Weight & Height:			
Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other: _____			
Who may we thank for referring you to our office?			
Blood Type:		Do you bruise easily? Y / N	
Is your visit due to an auto accident? Y / N		Is your visit due to another accident (ex. Work)? Y / N	
Have you received acupuncture before? Y / N		If yes. When was your last treatment?	
Results?			

## Employment Information

Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Student	Hours per week:
Occupation:	Employer Name:

## Referring Healthcare Provider

Physician:	Tel:
Physician Address:	Date of last visit:

## Insurance/Super-bill Information

Insurance Company:	Policy holders name:			
Policy Name (if applicable):	Employer Name (if applicable):			
Policy Number:				
Insurance Company Tel:	Fax:	Address:		
Spoke with:	Ded:	Policy start date:	Co-pay:	# Of visits
Ded met:	Office visit covered:			

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## Illness and Treatment Information

Are you presently being treated for a medical condition? No  Yes  Please Describe

What are your goals for your health? What health issues do you want to address?

What other medical or treatment therapies are you currently receiving ?

Other health concerns & information I should know about you:

Family History - Complete for each family member, indication any of the illnesses that they have ever had. Place an "X" in the appropriate box or boxes.

	mother	father	sibling	spouse	children
Cancer or tumors					
diabetes					
Blood or bleeding disorders/anemia					
seizures					
High blood pressure/heart disease					
allergies					
stroke					
Drug abuse					
Depression or mental illness					
Age of death - cause					
hepatitis					
Kidney disorders					
Thyroid disorders					
Musculo-skeletal disorder					
Blood transfusion (if before 1985)					

Medicines: Please list all current medications

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Acetaminophen (Tylenol)
<input type="checkbox"/> Oral Contraceptives	<input type="checkbox"/> Laxatives	<input type="checkbox"/> Fiber Supplements
<input type="checkbox"/> Sleeping Pills	<input type="checkbox"/> Tranquilizers	<input type="checkbox"/> Cold Tablets
<input type="checkbox"/> Diet Pills	<input type="checkbox"/> Antacid	<input type="checkbox"/> Hay fever Tablets
<input type="checkbox"/> Blood pressure	<input type="checkbox"/> Blood Thinning	<input type="checkbox"/> Insulin, Diabetic Meds.
<input type="checkbox"/> Vitamins		
<input type="checkbox"/> Herbs:		
<input type="checkbox"/> Other:		

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Aids/HIV		Alcoholism/Substance Abuse
Allergies		Hepatitis A / B / C
Allergies to Cosmetics		Herpes
Allergy to Latex		Lyme Disease
Asthma		Mitral Valve Prolapse
Cancer		Multiple Sclerosis
Emphysema		Pacemaker
Birth Trauma		Polio / Measles / German Measles
Diabetes		Rheumatic Fever / Chicken Pox
Heart Disease		Scarlet Fever / Diphtheria / Mumps
Seizures		Tuberculosis
Lymph nodes removed		Varicose Veines
Blood disorders		Blood Pressure: <span style="float: right;">last date taken:</span>
Kidney or Bladder disorders		Stomach or Intestinal disorders
Stroke		Depression/Mental disorders
Other:		

## Major Hospitalizations

Year	Operation or Illness	Hospital Name	City, State
Year	Operations or Illness	Hospital Name	City, State
Year	Operation or Illness	Hospital Name	City, State

## Drug Allergies/reactions: please list

## Environment & Diet Allergies: please list

## Exercise

Do you exercise regularly? Y / N    What type?  
 How often and for how long?

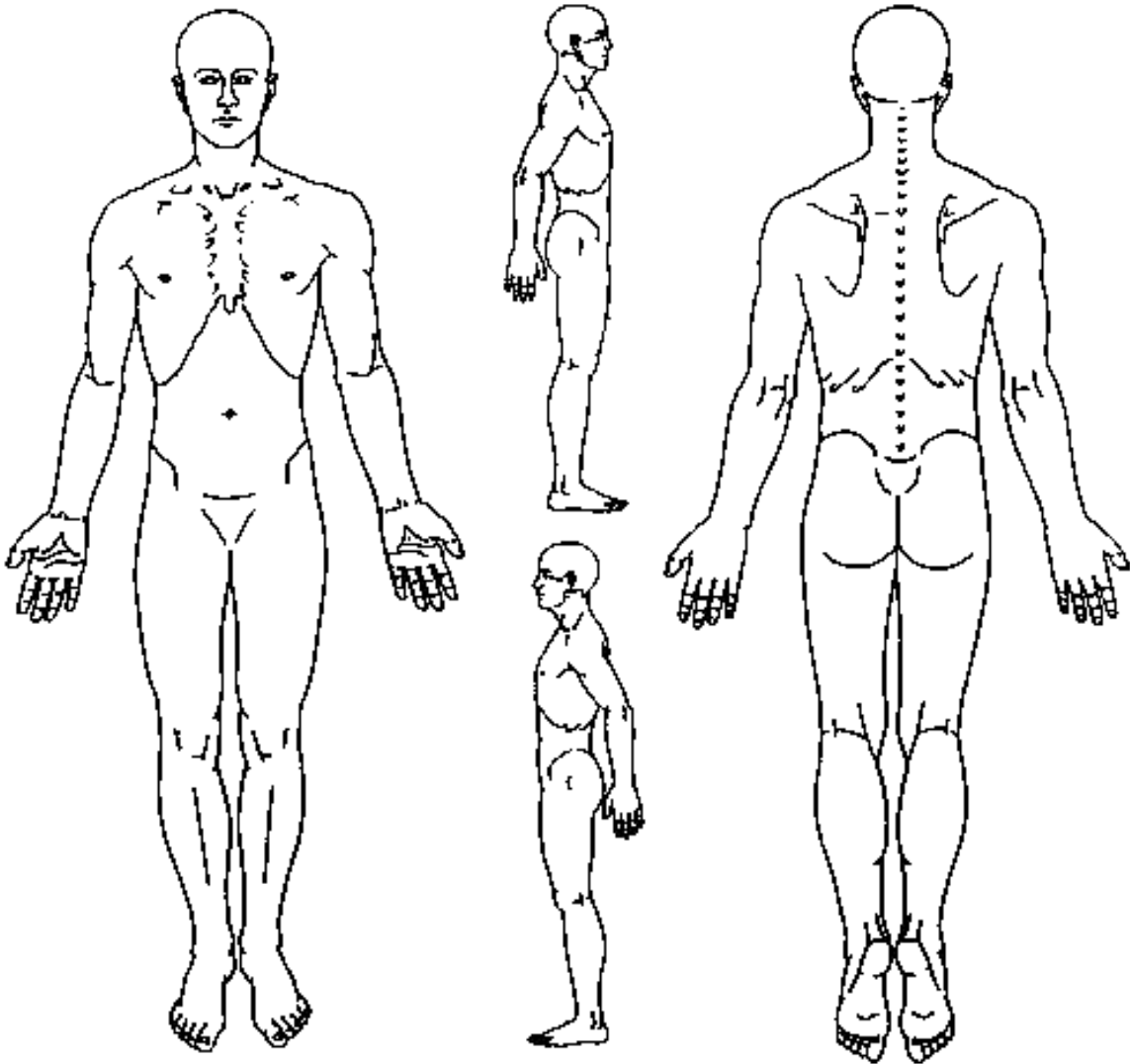
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## Habits

Coffee	No	Yes	Cups per day / Week	Age started	Age Quit
Tobacco	No	Yes	Cigs per day / Week		
Alcohol	No	Yes	Drinks per day / Week		
Marijuana	No	Yes	Use per day / Week		
Other	No	Yes	Use per day/ Week		

Musculo-skeletal: please mark an "X" to indicate areas where you feel pain, swelling, or discomfort. Describe what you feel or observe in your own words. Write anywhere in this area. Be sure to include all chronic pain.





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Health History: check all that apply

<b>General</b>			<b>Eyes</b>			<b>Gastro-intestinal</b>		
<u>Past</u>	<u>Present</u>	<u>Condition</u>	<u>Past</u>	<u>Present</u>	<u>Condition</u>	<u>Past</u>	<u>Present</u>	<u>Condition</u>
[ ]	[ ]	Fatigue	[ ]	[ ]	Blurred Vision	[ ]	[ ]	Nausea/vomit
[ ]	[ ]	Sweats Easily	[ ]	[ ]	Poor Night Vision	[ ]	[ ]	Poor Appetite
[ ]	[ ]	Night Sweats	[ ]	[ ]	Spots	[ ]	[ ]	Excessive Appetite
[ ]	[ ]	Chills	[ ]	[ ]	Cataracts	[ ]	[ ]	Diarrhea
[ ]	[ ]	Fever	[ ]	[ ]	Glasses/Contacts	[ ]	[ ]	Constipation
[ ]	[ ]	Insomnia	[ ]	[ ]	Dryness	[ ]	[ ]	Bloating
[ ]	[ ]	Localized Weakness	[ ]	[ ]	Other_____	[ ]	[ ]	Indigestion/Acid Regurg
[ ]	[ ]	Poor Coordination				[ ]	[ ]	Bad Breath
[ ]	[ ]	Poor Appetite	<b>Cardiovascular_</b>			[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Excessive Appetite	<u>Past</u>	<u>Present</u>	<u>Condition</u>	[ ]	[ ]	Rectal Pain
[ ]	[ ]	Change in Appetite	[ ]	[ ]	High Blood Pressure	[ ]	[ ]	Gallbladder Disorder
[ ]	[ ]	Strong Thirst	[ ]	[ ]	Low Blood Pressure	[ ]	[ ]	Other_____
			[ ]	[ ]	Blood Clots			
			[ ]	[ ]	Palpitations	<b>Neurological</b>		
			[ ]	[ ]	Fainting	<u>Past</u>	<u>Present</u>	<u>Condition</u>
<b>Skin &amp; Hair</b>			[ ]	[ ]	Chest Pain	[ ]	[ ]	Seizures
<u>Past</u>	<u>Present</u>	<u>Condition</u>	[ ]	[ ]	Irregular Heart Beat	[ ]	[ ]	Tremors
[ ]	[ ]	Rashes	[ ]	[ ]	Cold Hands/Feet	[ ]	[ ]	Numbness/Tingling
[ ]	[ ]	Hives	[ ]	[ ]	Other_____	[ ]	[ ]	Paralysis
[ ]	[ ]	Eczema				[ ]	[ ]	Other_____
[ ]	[ ]	Pimples	<b>Respiratory</b>					
[ ]	[ ]	Dryness	<u>Past</u>	<u>Present</u>	<u>Condition</u>	<b>Psychological</b>		
[ ]	[ ]	Lumps	[ ]	[ ]	Asthma	<u>Past</u>	<u>Present</u>	<u>Condition</u>
<b>Head &amp; Neck</b>			[ ]	[ ]	Bronchitis	[ ]	[ ]	Depression
<u>Past</u>	<u>Present</u>	<u>Condition</u>	[ ]	[ ]	Frequent Colds	[ ]	[ ]	Anxiety/Stress
[ ]	[ ]	Dizziness	[ ]	[ ]	COPD	[ ]	[ ]	Irritability/Anger
[ ]	[ ]	Fainting	[ ]	[ ]	Pneumonia	[ ]	[ ]	Nervousness
[ ]	[ ]	Headaches/Migraines	[ ]	[ ]	Cough	[ ]	[ ]	Treated for Emotional or
[ ]	[ ]	Head Feels Heavy	[ ]	[ ]	Other_____	[ ]	[ ]	Psychological problems
[ ]	[ ]	TMJ/Jaw Tension				[ ]	[ ]	Other_____
[ ]	[ ]	Other_____	<b>Genito-urinary</b>					
<b>Nose, Throat, Mouth</b>			<u>Past</u>	<u>Present</u>	<u>Condition</u>	<b>Infectious</b>		
<u>Past</u>	<u>Present</u>	<u>Condition</u>	[ ]	[ ]	Kidney Stones	<u>Past</u>	<u>Present</u>	<u>Condition</u>
[ ]	[ ]	Nose Bleeds	[ ]	[ ]	Painful Urination	[ ]	[ ]	HIV
[ ]	[ ]	Sinus Infections	[ ]	[ ]	Frequent Urination	[ ]	[ ]	Hepatitis
[ ]	[ ]	Hay Fever or Allergies	[ ]	[ ]	Blood in Urine	[ ]	[ ]	Syphilis
[ ]	[ ]	Recurring Sore Throats	[ ]	[ ]	Urgency to Urinate	[ ]	[ ]	Genital Warts/HPV
[ ]	[ ]	Other_____	[ ]	[ ]	Incontinence/Dribbling	[ ]	[ ]	Herpes
			[ ]	[ ]	Other_____	[ ]	[ ]	Other_____
<b>Ears</b>								
<u>Past</u>	<u>Present</u>	<u>Condition</u>						
[ ]	[ ]	Infection						
[ ]	[ ]	Ringing						
[ ]	[ ]	Decreased Hearing						