6319 N. Fresno St., #102
Fresno, CA 93710
Tel: 559-573-2022 / Fax: 559-439-2720

Healing Hand
ACUPUNCTURE & HERBS CLINIC

300 E. Mineral King Ave., # 202
Visalia, CA 93291
Tel: 559-375-5518 / Fax: 559-439-2720

Welcome

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Date_____

Name (Last, First, Mi) _____ DOB _____ SSN_____

Address _____ City_____ State _____ Zip _____

Phone (C) (_____)_____ (W)(_____)_____ (e-mail) _____

Sex ☐Male ☐Female Check appropriate box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed

Height _____ Weight _____

Occupation_____ Employer_____

Emergency Contact Name _____ Relationship_____ Phone # _____

Whom may we thank for referring you? _____

Primary Care Doctor Name: _____ Phone (_____)_____

Specialist Name: _____ Phone (_____)_____

Insurance Information (if different please fill out)

Primary & Secondary

Name of Insured _____ Insured Date of Birth _____

Insurance Company _____ Policy ID # _____-_____

RELEASE OF INFORMATION

I certify that I am at least 18 years of age (or if under 18 years of age, that I am joined herein by my parent or legal guardian) and that this release of information is signed voluntarily including the diagnosis, records; Examination rendered to me and claims information. This Release of Information will remain in effect until terminated by me in writing.

Patient Signature _____ Date:_____

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Name:_____ DOB:_____ Date:_____/_____/_____

Patient Medical Complaints (List Below)

1. _____ 4. _____
2. _____ 5. _____
3. _____

Do these conditions impair your daily activities? If so, how? _____

How would you classify your condition? □ minor □ progressively getting worse □ serious

Medication(s): _____

Supplements: _____

Please answer the following:

Previous Illnesses: _____

Previous Surgery: _____

Current Work Status: _____

Alcohol: _____

Tobacco Use: _____

(Please indicate if you have any of the following)
□ Fever □ Weight loss □ Cough
□ Vision changes □ Seizure □ Weakness
□ Congestion □ Sore throat □ Hearing changes
□ Shortness of breath □ Wheezing □ Chest pain
□ Chest palpitations □ Irregular heartbeats
□ Nausea □ Vomiting □ Diarrhea □ Abdominal pain
□ Difficulty or pain with urination □ Vaginal discharge
□ Irregular period □ Heavy Flow □ Clots □ Pain □ Color (ex. dark brown) _____
□ Depression □ Anxiety □ Sleeping issues

List allergies (if any):

_____

_____

_____

_____

_____

_____

Family Medical History: Has your father/mother ever had the following:

	Mom	Dad		Mom	Dad
Stroke	□	□	Diabetes	□	□
Asthma	□	□	High Blood Pressure	□	□
Allergies	□	□	Mental Disorder	□	□
Cancer	□	□			