FLOWING HEALTH 7005 7th Ave NW Unit B ~ Seattle, WA 98117 ☎ 206.635.7704 🖷 206.649.8045

PATIENT CONTACT INFORMATION

Name _____ Date_____
First Middle Last

Address _____ Occupation _____
Street

_____ Gender (circle) nb male female
City State Zip Code

Best contact phone number_____ Age _____ DOB____/____/____

May we send or email you newsletters/health related mailings? yes ☐ no ☐

Email _____ Note: email is not HIPAA compliant and therefore not the best way to communicate health issues with your doctor.

Emergency contact _____
Name Phone number Relationship

REASON FOR VISIT

What are your most important health concerns? Please list your present health concerns or symptoms:

HEALTH INFORMATION

Do you have any allergies? no ☐ yes ☐
Please list allergies to drugs, foods or environmental factors and your reactions below.

_____

_____

Do you take any of the following medications?

	No	Yes		No	Yes		No	Yes
Pain relievers (aspirin, ibuprofen, etc)	☐	☐	Antibiotics	☐	☐	Antacids	☐	☐
Blood thinners (warfarin, coumadin)	☐	☐	Heart medication	☐	☐	Laxatives	☐	☐
Cortisone (creams or pills)	☐	☐	Sleeping pills	☐	☐	Sedatives	☐	☐

Are you currently taking any prescription medications, over-the-counter medications, vitamins or other nutritional/herbal supplements? no ☐ yes ☐ If yes, please list them all below.

_____

_____

What hospitalizations, surgeries, injuries, or serious illnesses have you had?

_____

When was your last physical exam?_____ How about blood work?_____

Have you ever had acupuncture before? no ☐ yes ☐

How did you hear about us? _____

What do you do to manage your stress levels/what is your favorite thing to do?

_____

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PATIENT HEALTH HISTORY

Do you have a personal or family history of the following?

	No	Yes*
Anemia	☐	☐
Arthritis	☐	☐
Cancer	☐	☐
Asthma	☐	☐
Hay fever/hives	☐	☐
Kidney disease	☐	☐
Stroke	☐	☐
Heart disease	☐	☐
Heart valve issue	☐	☐
High blood pressure	☐	☐
Thyroid problems	☐	☐
Diabetes	☐	☐
Mental disorder	☐	☐
Epilepsy	☐	☐
Hepatitis	☐	☐
Liver Disease	☐	☐
Tuberculosis	☐	☐
HIV	☐	☐
Other major disease	☐	☐

Describe_____

*if a family member please list who: mother (M), father (F), sister (S), aunt (A), grandfather (GF), grandmother (GM) etc.

Do you have any of the following symptoms/conditions? Circle if you have had them in the past.

	No	Yes		No	Yes		No	Yes
Cold hands/feet	☐	☐	Skin rashes	☐	☐	Jaw pain/TMJ	☐	☐
Numbness/tingling	☐	☐	Skin lumps	☐	☐	Ringing in the ears	☐	☐
Muscle aches	☐	☐	Itching	☐	☐	Loss of hair	☐	☐
Neck pain/stiffness	☐	☐	Diarrhea	☐	☐	Acne or boils	☐	☐
Back pain or Sciatica	☐	☐	Constipation	☐	☐	Eye problems	☐	☐
Shooting pain	☐	☐	Bloating	☐	☐	Spitting up blood	☐	☐
Burning pain	☐	☐	Heartburn	☐	☐	Blood in stool	☐	☐
Migraines or headaches	☐	☐	Ulcers	☐	☐	Blood clots	☐	☐
Sinus problems	☐	☐	Chest pain	☐	☐	Varicose veins	☐	☐
Pneumonia	☐	☐	Weakness	☐	☐	Head injury	☐	☐
Shortness of breath	☐	☐	Cramping	☐	☐	Paralysis	☐	☐
Frequent colds	☐	☐	Joint pain	☐	☐	Sleep issues	☐	☐
Stomach aches	☐	☐	Sore throat	☐	☐	Stress/irritability	☐	☐
Anxiety or depression	☐	☐	Cough	☐	☐	Sexual difficulty	☐	☐
Low blood pressure	☐	☐	Fever	☐	☐	Low libido	☐	☐
Easy bruising/bleeding	☐	☐	Fainting	☐	☐	Gonorrhea	☐	☐
Night Sweats	☐	☐	Fatigue	☐	☐	Herpes	☐	☐
Loss of memory	☐	☐	Murmur	☐	☐	Chlamydia	☐	☐
Frequent urination	☐	☐	Dizziness	☐	☐	Other STD	☐	☐
Skin color changes	☐	☐	Seizures	☐	☐			

Describe:_____

Please describe any other symptoms below if you would like:

_____

Do you have any of the following:	No	n/a	Yes		No	n/a	Yes		No	n/a	Yes
Regular periods?	☐	☐	☐	Uterine fibroids?	☐	☐	☐	Testicular mass?	☐	☐	☐
Painful menses?	☐	☐	☐	Breast lumps?	☐	☐	☐	Discharge?	☐	☐	☐
Abnormal bleeding?	☐	☐	☐	Breast tenderness?	☐	☐	☐	Prostate issues?	☐	☐	☐
Hot flashes?	☐	☐	☐	Fertility issues?	☐	☐	☐	Hernia?	☐	☐	☐

Are you currently or possibly pregnant? No ☐ n/a ☐ Yes ☐

Number of pregnancies: _____ Number of live births:_____ What type of birth control, if any _____

PLEASE READ AND SIGN BELOW

I understand that my personal health information is confidential and consent to the use and disclosure of my health information for the purposes of treatment, payment, and healthcare operations or as otherwise required by law. I have looked over and understand the HIPAA privacy policy.

I understand that my practitioner may leave a phone message for me regarding any pertinent health related information.

I understand and agree that all fees for professional services rendered on my behalf are my personal responsibility and due and payable at the times services are rendered unless other arrangements have been made in advance.

I understand that even if I am covered by my health insurance, it is possible I will still owe fees to the practitioner at a later date due to unforeseen restrictions or because my health insurance company may not cover services in full and I will remit payment to the clinic in a timely manner when requested to do so accordingly (past due invoices will be subject to a 1.5% finance charge; unpaid invoices that are 30 days past the 3rd & final notice will be handed off to collections).

Signature of Responsible Party:_____ **Date:**_____/_____/_____

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