Patient Information (CONFIDENTIAL) Date___ / ___ / ___

First M Last

Address

City State Zip

Email

___ /___ /___ ________
Date of Birth Age

○ F ○ M

Occupation

(______) _______-________
Home Phone

(______) _______-________
Work Phone

(______) _______-________
Mobile Phone

Primary Contact #
○ Hm ○ Wk ○ Mbl

Physician Phone

How did you hear about us?

Main reason for appointment?

How long have you had this problem? Sudden or gradual?

Have you been to a Western Dr. for this problem?

If yes, what were the findings?

Are you pregnant now? Are you trying to get pregnant now?

Do you smoke? If yes, how many per day?

Do you drink alcohol? If yes, how much per week?

Emergency

Contact

Relationship

(______) _______-________
Phone

List all medications taken on a daily basis:

List all herbs or supplements:

Sample Diet:

Breakfast	Snack	Lunch	Snack	Dinner	Snack

Family History:

❍ Blood Pressure ❍ Cancer ❍ Tinnitus ❍ Parkinson's
❍ Heart Disease ❍ Migraines ❍ Asthma ❍ Sinus
❍ Diabetes ❍ Stroke ❍ Depression ❍ Other_________

Your Past History:

❍ Asthma ❍ Diabetes ❍ Parkinson's ❍ Stroke
❍ High Blood Pressure ❍ Migraines ❍ Sinus ❍ Headaches
❍ Heart Disease ❍ Depression ❍ Diarrhea ❍ PMS
❍ Cancer ❍ Tinnitus ❍ Constipation ❍ Birth Trauma
❍ Aids/HIV ❍ Alcoholism ❍ Allergies ❍ Addiction
❍ Emphysema ❍ Pacemaker ❍ Multiple Sclerosis❍ Herpes
❍ Hepatitis A/B/C ❍ Fibromyalgia ❍ Polio ❍Seizures
❍ Rheumatic Fever ❍ Tuberculosis ❍ Other________________________________

Exercise and Energy:

What is your energy level? 1 (low) -10 (high)? ____

Does your energy drop at a certain time of day? ___________________If yes, when? _______________

Do you fatigue easily? ____

What kind of exercise routine do you have? ____

Emotions and Sleep:

Do you have:

❍ Anxiety ❍ Difficult Concentrating ❍ Depression ❍ Bad Temper
❍ Fear Attacks ❍ Nervousness ❍ Panic Attacks ❍ Poor Memory

How many hours do you sleep a night? ____

Is it difficult for you to fall asleep or stay asleep? ____

Do you wake up at a certain time during the night?________________ If yes, what time__________

Do you dream at night? ____________________If yes, do they wake you up? ______________________

Gastrointestinal:

Do you experience:

❍ Belching ❍ Nausea ❍ Vomiting ❍ Ulcers
❍ Bloating ❍ Acid Regurgitation ❍ Heartburn ❍ Indigestion
❍ Stomach Pain

Bowel Movements:

How many per day? ____________________

Do you feel better or worse after a bowel movement? ____________________

Check all that apply:

❍ Irregular BM ❍ Constipation ❍ Diarrhea ❍ Gas
❍ Burning Sensation ❍ Hemorrhoids ❍ Undigested food in stool ❍ Hard Stool
❍ Loose Stool ❍ Painful BM ❍ Blood in Stool ❍ Itchiness

Urinary:

Urination: How many times per day?____________________Color____________________

Check all that apply:

❍ Frequent ❍ Trouble starting a stream ❍ Pain ❍ Incontinence
❍ Burning ❍ Dribbling when sneezing ❍ Blood in Urine ❍ Kidney Stones
❍ UTI ❍ Other____________________

Women:

What age did you start menstruating? ____________Number of days between cycle____________

Number of days of flow ____________Is flow light or heavy? ____________

Color of the blood ____________Spotting? ____________

Do you have any clots? ____________ Pain before or after? ____________

PMS ____________Vaginal Discharge? ____________

Men:

Check all that apply:

❍ Prostatitis ❍ Impotence ❍ Other____________________

Cardiovascular:

Check all that apply:

- ❍ Chest Pain
- ❍ Palpitations
- ❍ Varicose Veins
- ❍ Phlebitis
- ❍ Cold Hands & Feet
- ❍ Irregular Heart Beat
- ❍ Poor Circulation
- ❍ Other____

Skin and Hair:

Check all that apply:

- ❍ Dry Skin
- ❍ Skin Rash
- ❍ Itching
- ❍ Acne
- ❍ Eczema
- ❍ Hives
- ❍ Premature Graying
- ❍ Hair Loss
- ❍ Other_______________

Eyes, Ears, Nose & Throat:

Check all that apply:

- ❍ Frequent Colds
- ❍ Pain Inhaling
- ❍ Shortness of Breath
- ❍ Asthma
- ❍ Chronic Runny Nose
- ❍ Nose Bleeds
- ❍ Poor Vision
- ❍ Floaters
- ❍ Bleeding Gums
- ❍ Painful / Red Eyes
- ❍ Ringing of the Ear
- ❍ Ear Pain
- ❍ Dizziness
- ❍ Dry Mouth
- ❍ Clogged Ears
- ❍ Cold Sores
- ❍ Coughing of Blood / Mucus

Headaches:

Do you get Headaches? ________________ If Yes, how often? _______________________________

Where are they located? _______________ Do they affect your vision? _______________________

Type of Pain:

- ❍ Sharp
- ❍ Dull
- ❍ Heavy
- ❍ Throbbing
- ❍ Other____

Generals:

Check all that apply for the last 2 months:

- ❍ Change of Appetite
- ❍ Sudden Drop of Energy
- ❍ Dizziness
- ❍ Fever
- ❍ Poor Sleep
- ❍ Migraines
- ❍ Sweats Easy
- ❍ Edema
- ❍ Facial Pain
- ❍ Night Sweats
- ❍ Bleed or Bruise Easy
- ❍ Vision Change
- ❍ Local Weakness
- ❍ Poor Balance
- ❍ Eye Dryness
- ❍ Tremors
- ❍ Cravings
- ❍ Sinus Congestion
- ❍ Peculiar Taste or Smell
- ❍ Chills
- ❍ Strong Thirst
- ❍ No Thirst
- ❍ Weight gain or loss
- ❍ Loss of Hair
- ❍ Other ______________________Please use space below for any additional comments:

ACKNOWLEDGEMENT FORM

Cancellation Policy: ________________
Initials

I understand and agree Roman's Acupuncture requires a 24-hour advance notice to cancel a scheduled appointment or service. Roman's will also reserve the right to bill customer 60% of scheduled service if 24-hour advance cancellation notice is not provided.

Consent Notice: ________________
Initials

I hereby give my permission and consent to be treated by Dr. Stacy Roman, OMD
Roman's Acupuncture and Herbal Clinic 1762 Blue Horizon Drive Morgantown WV 26501

Privacy Practices: ________________
Initials

We adhere to the HIPPA Privacy Policies, we are no longer required to supply a copy of this material, however, if you do have any questions the Policy is posted in our front office.

Payment Policy: ________________
Initials

I understand and agree that Roman's Acupuncture requires payment in Full at the day and time of appointment. If at any time you choose to pay with a check, and it is returned for non-payment, you will be charged the returned check fee.

Return Policy: ________________
Initials

All service packages sold at Roman's are NON-REFUNDABLE. Packages may be exchanged for other services only and must be used within one year of original purchase date.

All supplements sold at Roman's are NON-REFUNDABLE. Some supplements require refrigeration. Roman's cannot accept opened or unopened supplements once they leave our clinic.

____   _____ / _____ / _____
Name (Printed)   *Birth Date*

____   ____________________
Signature   *Date*