

Patient Information (CONFIDENTIAL)

Date ___ / ___ / ___

First	M	Last
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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:

- | | | | |
|--------------------------------------|---------------------------------|----------------------------------|-----------------------------------|
| <input type="radio"/> Blood Pressure | <input type="radio"/> Cancer | <input type="radio"/> Tinnitus | <input type="radio"/> Parkinson's |
| <input type="radio"/> Heart Disease | <input type="radio"/> Migraines | <input type="radio"/> Asthma | <input type="radio"/> Sinus |
| <input type="radio"/> Diabetes | <input type="radio"/> Stroke | <input type="radio"/> Depression | <input type="radio"/> Other_____ |

Your Past History:

- | | | | |
|---|------------------------------------|--|------------------------------------|
| <input type="radio"/> Asthma | <input type="radio"/> Diabetes | <input type="radio"/> Parkinson's | <input type="radio"/> Stroke |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Migraines | <input type="radio"/> Sinus | <input type="radio"/> Headaches |
| <input type="radio"/> Heart Disease | <input type="radio"/> Depression | <input type="radio"/> Diarrhea | <input type="radio"/> PMS |
| <input type="radio"/> Cancer | <input type="radio"/> Tinnitus | <input type="radio"/> Constipation | <input type="radio"/> Birth Trauma |
| <input type="radio"/> Aids/HIV | <input type="radio"/> Alcoholism | <input type="radio"/> Allergies | <input type="radio"/> Addiction |
| <input type="radio"/> Emphysema | <input type="radio"/> Pacemaker | <input type="radio"/> Multiple Sclerosis | <input type="radio"/> Herpes |
| <input type="radio"/> Hepatitis A/B/C | <input type="radio"/> Fibromyalgia | <input type="radio"/> Polio | <input type="radio"/> Seizures |
| <input type="radio"/> Rheumatic Fever | <input type="radio"/> Tuberculosis | <input type="radio"/> 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:

- | | | | |
|------------------------------------|---|-------------------------------------|-----------------------------------|
| <input type="radio"/> Anxiety | <input type="radio"/> Difficult Concentrating | <input type="radio"/> Depression | <input type="radio"/> Bad Temper |
| <input type="radio"/> Fear Attacks | <input type="radio"/> Nervousness | <input type="radio"/> Panic Attacks | <input type="radio"/> 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

Bowell 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
 - Cold Hands & Feet
 - Other _____
 - Palpitations
 - Irregular Heart Beat
 - Varicose Veins
 - Poor Circulation
 - Phlebitis
-

Skin and Hair:

Check all that apply:

- Dry Skin
- Eczema
- Other _____
- Skin Rash
- Hives
- Itching
- Premature Graying
- Acne
- Hair Loss

Eyes, Ears, Nose & Throat:

Check all that apply:

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

Headaches:

Do you get Headaches? _____ If Yes, how often? _____

Where are they located? _____ Do they affect your vision? _____

Type of Pain:

- Sharp
 - Other _____
 - Dull
 - Heavy
 - Throbbing
-

Generals:

Check all that apply for the last 2 months:

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

Please use space below for any additional comments:

Roman's Acupuncture & Herbal Clinic, LLC
1762 Blue Horizon Drive
Morgantown WV 26501
www.romansacupuncture.com
(304) 322 0093

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

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Payment Policy: _____
Initials

I understand and agree that Roman's Acupuncture requires payment in Full at the day and time of appointment.

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