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

Bowel Movements:

How many per day? _____

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

Check all that apply:

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

Urinary:

Urination: How many times per day?_____Color_____

Check all that apply:

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

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:

_____

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

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*