ADULT PATIENT PROFILE

NAME:_____ DATE:_____

ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____ COUNTY: _____

PHONE #: _____ WORK #: _____

EMAIL: _____

Would you like to receive our informational newsletter, including coupons? Y☐☐o

Who can we thank for referring you?_____

AGE: _____ HEIGHT: _____ WEIGHT: _____ DOB:_____ ☐ / ☐

****KNOWN ALLERGIES****: _____

Do you have a pacemaker? ☐☐ Have you had any organ transplants? ☐☐

Please list, in order of importance, your primary health concerns:

1. _____ 3._____

2._____ 4._____

Please list any medically diagnosed diseases:

_____

Please list any pharmaceutical medications that you are currently taking:

_____

_____

Please list any nutritional supplements that you are currently taking:

_____

_____

_____

Please list any surgeries you have had, along with the dates:

_____

_____

Date of last physical/check up: _____ Marital Status: _____

Occupation: _____ Retired?: _____

Where were you raised? _____ Blood Type? _____

Vaccinated? YES: _____ NO:_____ SOME: _____

List any diseases that are prominent in your family: (Indicate whether on Mother or Father's side)

_____

_____

LIFESTYLE PROFILE

Are/Were you a smoker? _____ How long? _____ How much? _____ Quit? _____

Did/Do you drink coffee? _____ How long? _____ How much? _____ Quit? _____

Did/Do you drink carbonated beverages? _____ How much? _____ Quit? _____

Do you eat seafood? What type and how frequently? _____

Do you exercise? _____ How Often? _____ What type? _____

How many amalgam (silver) dental fillings do you have? _____Have you had any fillings removed? _____

How many root canals do you have? _____ Crowns? _____ Implants? _____

Have you ever been exposed to extreme mold for a prolonged time period? _____

Have you ever suffered from an extreme trauma? Either emotional or physical. _____

What brand of toothpaste do you use? _____ Deodorant Brand?_____

Do you have family pets? Dogs? _____ Cats? _____ Other? _____

Do you sleep with a sleep number bed, electric blanket, or heating pad? _____

Are there any high-tension power lines or transformers near your home or where you work? _____

List any foods that you currently avoid? _____

How often do you have a bowel movement? _____

PLEASE GIVE A GENERAL DIET SUMMARY FOR THE LAST THREE DAYS:

	BREAKFAST	LUNCH	DINNER	SNACKS
DAY 1				
DAY 2				
DAY 3				

****

WOMEN ONLY:

Date of last menstruation: _____

Are you now on or have you ever taken birth control? _____ How long? _____

If menopausal; date of last GYN visit: _____

Are you pregnant or nursing? _____ Do you have children? _____ How many? _____

Check those that apply: PMS ☐ Heavy Periods ☐ Irregular Periods ☐ Cysts/Fibroids ☐

Have you had any cosmetic surgery? _____

SYMPTOM PROFILE

Patient Name: _____ Date: _____

Please rate the severity of your symptoms LEAST WORST

Brain Fog ○○○○ ○○○○ ○○○

Neck/Upper Back Pain ○○○○ ○○○○ ○○○

Joint/Muscle Pain-*Location:* _____ ○○○○ ○○○○ ○○○

Headaches/Migraines ○○○○ ○○○○ ○○○

Tingling/Numbness in Extremities ○○○○ ○○○○ ○○○

Blurry vision / Floaters ○○○○ ○○○○ ○○○

Digestive Dysfunction ○○○○ ○○○○ ○○○

☐ **Gas/Bloating** ☐ **ndigestion/Reflux** ☐ **Diarrhea/Constipation**

Insomnia / Sleep disturbance ○○○○ ○○○○ ○○○

Fatigue/Exhaustion ○○○○ ○○○○ ○○○

Anxiety ○○○○ ○○○○ ○○○

Depression ○○○○ ○○○○ ○○○

Cardiovascular issues ○○○○ ○○○○ ○○○

Sinus / Chest Congestion ○○○○ ○○○○ ○○○

Hormone/Endocrine Imbalance ○○○○ ○○○○ ○○○

Skin Rash / Irritation ○○○○ ○○○○ ○○○

Urinary tract/Kidney dysfunction ○○○○ ○○○○ ○○○

Authorization to Release Health Information

I authorize **Longevity Health Center** to disclose my protected past, present and future health information to the following persons or entities:

_____ _____

This health information may be used by the person I authorize for health treatment or billing/payment purposes. This authorization will remain in effect until such time as I choose to revoke the authority in writing.

⏩⏩_____

Signature **Date**

STATEMENT OF UNDERSTANDING

The modalities employed by **Seneca Anderson, ND, L.Ac., Alice Honican, ND, L.Ac., Anna Powers, ND, Cristina McMullen, ND. and Maria Jones, ND.** are not approved for any sort of medical evaluation. Bio-energetic evaluation will reveal "**disturbance signals**" for microbial and environmental pollutants. This evaluation should in no way be construed as a medical diagnosis. The information gathered is used to guide the recommended protocol.

I understand that none of the practitioners or the associates or staff of Longevity Health Center are medical doctors. I choose to undergo an evaluation and treatment in accordance with oriental medicinal principles, utilizing techniques of traditional and modern acupuncture.

CANCELLATION POLICY - $50 missed appointment fee

Late Cancellations/No-Shows

A cancellation is considered late when the appointment is cancelled less than **24 hours** before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, we will charge the patient a **$50** missed appointment fee. Our goal is to provide quality health care to all our patients in a timely manner. Please be aware of our policy regarding missed appointments. When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. **If cancellation is necessary, we require that you call at least 24 hours in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.**

If you need to cancel your appointment, please call us at **770-642-4646** between the hours of **9am to 5pm** If necessary, you may leave a detailed voicemail message. We will return your call as soon as possible.

I have read and understand the above CANCELATION POLICY.
I have read and understand this STATEMENT OF UNDERSTANDING.

⏩⏩_____

Signature of Patient (or Parent of Minor) **Date**