

Welcome! Thank you for choosing this clinic. Please help us to help you by complete the following information as accurately as possible.

***Acupractic Natural Healing Center-serving the Triangle since 1995. We offer  
alternative medicine in a relaxed, unhurried atmosphere.***

*The care you are about to receive in this office is a synthesis of eastern and western alternative medicine approaches to health. In the orient, Tui Na (vertebral, soft tissue, and extremity adjustments) is an integral part of any treatment program, as is the use of acupuncture (needle or other point stimulation techniques) and herbal/vitamin prescription. Because we have become a nation of specialists it is rare in our culture to find a clinic where you can receive these treatments together. It is even rarer to find a clinic where one doctor performs both treatments for you and personally attends to each aspect of your care. You have this combined approach at Acupractic.*

*Alternative medicine- so called because it is a drugless, non-surgical approach to health, is also referred to as complimentary or integrative medicine because it can be used in conjunction with standard western medical treatments. Chiropractic physicians are well trained in determining the cause of problems and at various types of treatment, which may include acupuncture, adjustments, nutrition, exercise prescription. Whether you are receiving wellness treatment or you have suffered an injury, need a sports physical examination or want facial rejuvenation acupuncture, you can rest assured that your care will be caring here at Acupractic.*

***Chiropractic*** care is based on the scientific fact that your nervous system controls the function of every cell, tissue, organ and system of the body. Your nervous system consists of your brain, spinal cord, and millions of nerves. While your brain is protected by the skull, your spinal cord is protected by the 24 moving bones of the spine. Many everyday activities can cause these spinal bones to lose their normal position or motion. This can result in nervous system dysfunction, and ultimately, ill health. The chiropractic approach to better health is to detect, reduce, and help prevent nervous system dysfunction. (Back Talk Systems)

***Acupuncture*** is a treatment principle that recognizes there is an energy network (meridians) that travels just under the skin which communicates from the exterior to the internal organs and structures at over 1,000 acupuncture points all over the body. The energy carried in the meridians is called qi (pronounced chee) and it works in harmony with the body's circulatory, nervous, muscular, digestive, genitourinary and all other systems of the body. If this energy is weakened or blocked, an effect in a body system or anatomic location becomes evident. Stimulation of one or a combination of key acupuncture points helps restore harmony to the affected area. (Dr. John Amaro)

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*You deserve one-on-one personalized care which you will receive at Acupractic.*

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Acupractic Natural Healing Center Dr. Lisa Oskardmay, Licensed Chiropractic Physician, Board Certified in Acupuncture  
NCCAOM



Welcome! Thank you for choosing this clinic. Please help us to help you by complete the following information as accurately as possible.

**Patient Information** Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_ male \_\_\_\_ female, age: \_\_\_\_, birthday (mm/dd/yr) \_\_\_\_\_

\_\_\_\_ single, \_\_\_\_ married, \_\_\_\_ widowed, \_\_\_\_ separated, \_\_\_\_ divorced

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Spouse's name \_\_\_\_\_

**Assignment and Release**

I, the undersigned, certify that I (or my dependent) have insurance coverage with \_\_\_\_\_

I assign directly to Dr. Oskardmay all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Responsible party signature

\_\_\_\_\_  
Relationship Date

**Phone numbers**

Home \_\_\_\_\_ Work \_\_\_\_\_

E-mail: \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

**How would you like to be reminded of**

**appointments?** Circle one or more: E-mail

Phone: \_\_\_\_\_ Mail None

**IN CASE OF EMERGENCY CONTACT:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

**Are you interested in treatment utilizing:**

Chiropractic? Acupuncture? Both? Either?

Other: \_\_\_\_\_

**Insurance:** give us your card to copy

Who is responsible for this account? \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Subscriber's DOB: \_\_\_\_\_ Employer \_\_\_\_\_

Is this patient covered by additional insurance? Yes No

**How did you hear about our office?**

referral? Whom may we thank?: \_\_\_\_\_

web/online telephone directory insurance company

other: \_\_\_\_\_

**Accident Information:**

Is condition due to an accident? Yes No Date: \_\_\_\_\_

We are unable at this time to accept assignment on accident cases but will help you as much as possible with all billing paperwork and we will participate with your health insurance plans in accordance to our agreement with them as usual.



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### Confidential Patient Health History:

What is the main problem you would like us to address?

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)? \_\_\_\_\_

How long has it been since you first noticed any symptoms? \_\_\_\_\_

Have you been given a diagnosis for the problem by your family physician? \_\_\_\_\_

If so, what is it? \_\_\_\_\_

What kinds of treatment or therapy have you tried? \_\_\_\_\_

#### PAST MEDICAL HISTORY (PLEASE INCLUDE DATES)

Allergies

Cancer

Thyroid disease

Diabetes

Hepatitis

High Blood Pressure

Surgeries

Rheumatic fever

Heart disease

Birth trauma (prolonged labor, forceps deliver, etc)

Other significant illness (describe) \_\_\_\_\_

Accidents or significant trauma (describe) \_\_\_\_\_

#### FAMILY MEDICAL HISTORY

Allergies

Cancer

Stroke

Diabetes

Heart disease

Seizures

Asthma

High blood pressure

Other

#### LIFESTYLE

Do you follow a regular exercise program? \_\_\_\_\_ If so, please describe: \_\_\_\_\_

Please describe your average daily diet: \_\_\_\_\_

Please check any of the following habits that apply. How much and how often do you use them?

Cigarette smoking

Coffee, tea or cola

Alcoholic beverages

List medications taken within the last two months (vitamins, drugs, herbs, etc.): \_\_\_\_\_

Please describe any use of drugs for non-medical purposes: \_\_\_\_\_

#### OCCUPATION

Occupation stress factors (physical, psychological, chemical): \_\_\_\_\_



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**CHECK NEXT TO ANY CONDITIONS YOU HAVE EXPERIENCED. Include Dates.**

**GENERAL**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Poor appetite      | <input type="checkbox"/> Weight loss                 | <input type="checkbox"/> Fever                             |
| <input type="checkbox"/> Insomnia           | <input type="checkbox"/> Changes in appetite         | <input type="checkbox"/> Chills                            |
| <input type="checkbox"/> Disturbed sleep    | <input type="checkbox"/> Sweating easily             | <input type="checkbox"/> Sudden energy drop (time of day?) |
| <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Tremors                     | <input type="checkbox"/> Poor balance                      |
| <input type="checkbox"/> Cravings           | <input type="checkbox"/> Bleeding or bruising easily | <input type="checkbox"/> Stroke                            |
| <input type="checkbox"/> Strong thirst      | <input type="checkbox"/> Night sweats                |  |
| <input type="checkbox"/> Weight gain        |  |  |

Other unusual or abnormal conditions you have noticed in your general sense of health:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Neck Pain            | <input type="checkbox"/> Jaw Pain                    | <input type="checkbox"/> Loss of Bladder Control     |
| <input type="checkbox"/> Upper Back Pain      | <input type="checkbox"/> Joint Swelling or Stiffness | <input type="checkbox"/> Prostrate Problems          |
| <input type="checkbox"/> Mid Back Pain        | <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Ulcer                       |
| <input type="checkbox"/> Low Back Pain        | <input type="checkbox"/> Rheumatoid Arthritis        | <input type="checkbox"/> Liver/Gall Bladder Disorder |
| <input type="checkbox"/> Shoulder Pain        | <input type="checkbox"/> General Fatigue             | <input type="checkbox"/> Asthma                      |
| <input type="checkbox"/> Elbow/Upper Arm Pain | <input type="checkbox"/> Muscular Incoordination     | <input type="checkbox"/> Chronic Sinusitis           |
| <input type="checkbox"/> Wrist Pain           | <input type="checkbox"/> Visual Disturbances         | <input type="checkbox"/> Systemic Lupus              |
| <input type="checkbox"/> Hand Pain            | <input type="checkbox"/> Kidney Disorders            | <input type="checkbox"/> Epilepsy                    |
| <input type="checkbox"/> Hip/Upper Leg Pain   | <input type="checkbox"/> Bladder Infection           | <input type="checkbox"/> Dermatitis/Eczema/Rash      |
| <input type="checkbox"/> Knee/Lower Leg Pain  | <input type="checkbox"/> Painful Urination           | <input type="checkbox"/> HIV/AIDS                    |
| <input type="checkbox"/> Ankle/Foot Pain      |  |  |

Other Health Problems/Issues: \_\_\_\_\_

**SKIN OR HAIR**

- |                                      |                                       |   |
|--------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hair loss    | <input type="checkbox"/> Changes in texture of hair or skin |
| <input type="checkbox"/> Pimples     | <input type="checkbox"/> Recent moles |   |
| <input type="checkbox"/> Dandruff    |                                       |   |

Any other hair or skin problems \_\_\_\_\_

**HEAD, EYES, EARS, NOSE, THROAT**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Concussions     | <input type="checkbox"/> Sinus problems          | <input type="checkbox"/> Facial pain              |
| <input type="checkbox"/> Migraines       | <input type="checkbox"/> Recurrent sore throats  | <input type="checkbox"/> Teeth problems           |
| <input type="checkbox"/> Glasses         | <input type="checkbox"/> Nose bleeds             | <input type="checkbox"/> Headaches (where? When?) |
| <input type="checkbox"/> Earaches        | <input type="checkbox"/> Grinding teeth          | <input type="checkbox"/> Jaw Clicks/Pain          |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sores on lips or tongue |   |
| <input type="checkbox"/> Poor hearing    |  |   |

Any other head or neck problems \_\_\_\_\_



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**CARDIOVASCULAR**

- Low blood pressure
- Chest pain
- Irregular heartbeat
- Dizziness
- Phlebitis
- Fainting
- Cold hands or feet
- Swelling of hands/feet
- Blood clots
- Difficulty in breathing

Any other lung problems \_\_\_\_\_

**GASTROINTESTINAL**

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Gas
- Abdominal pain or cramps

Any other problems with stomach or intestines \_\_\_\_\_

**GENITOURINARY**

- Pain on urination
- Frequent urination
- Blood in urine
- Urgency to urinate
- Unable to hold urine
- Kidney stones
- Decrease in flow
- Impotence

Do you wake up at night to urinate? \_\_\_\_\_ If, so how often? \_\_\_\_\_

Any particular color to your urine? \_\_\_\_\_

Any other genital or urinary problems? \_\_\_\_\_

**REPRODUCTIVE AND GYNECOLOGIC**

- Premenstrual changes
- Menstrual clots
- Painful menses
- Unusual menses
- Irregular menses
- Other problems

Age at first menses \_\_\_\_\_ Age at menopause \_\_\_\_\_ Number of pregnancies \_\_\_\_\_

Time between cycles \_\_\_\_\_ Duration of bleeding \_\_\_\_\_ First day of last menses \_\_\_\_\_

Do you practice birth control? \_\_\_\_\_ If so, what type? \_\_\_\_\_ For how long? \_\_\_\_\_

Any other gynecologic problems \_\_\_\_\_

**NEUROPSYCHOLOGICAL**

- Seizures
- Dizziness
- Loss of balance
- Areas of numbness
- Lack of coordination
- Concussion
- Depression
- Anxiety
- Bad temper
- Easily susceptible to stress
- Poor memory

Any other neurological or psychological problems \_\_\_\_\_

**COMMENTS**

Please list any other problems you would like to discuss? \_\_\_\_\_

