DR. STEVE STROUD, N.D., L.Ac. Dipl. Ac. (NCCA)

CENTER FOR WHOLISTIC MEDICINE
WENATCHEE ACUPUNCTURE CLINIC, INC

310 S Mission St
Wenatchee, WA 98801
(509) 663-4365
www.wenatcheeacupunture.com

INTAKE FORM

Date _____

Name _____ Age _____ D.O.B. _____ M / F

Address_____ City_____ State _____ Zip_____

Phone: Home _____ Cell _____ Work _____

Email _____

Emergency Contact (name & phone) _____

Relationship Status _____ # Children _____

Occupation _____ Employer _____

How did you hear about our clinic? _____

Insurance _____ Subscriber _____

ID #_____ Group # _____

Current heath concerns and date of onset:

1)_____

2) _____

3) _____

4) _____

Previous Treatment _____

_____

Other Healthcare Providers _____

Current Medications _____

_____

Allergies _____

Current Supplements _____

_____

Exercise Routine _____

-Please continue on the other side-

Medical History: Please mark '**C**' **for current**, '**P**' **for past,** '**CH**' **for chronic** and **'O' for occasionally**.

____ Alcohol/Substance Abuse	____ Digestive Problems	____ Hypoglycemia
____ Allergies	____ Eating Disorder	____ Joint Problems
____ Anemia	____ Edema	____ Kidney Disease
____ Arthritis	____ Fatigue	____ Panic Attacks
____ Asthma	____ Gallbladder	____ Depression
____ Back Pain	____ Liver/Hepatitis	____ Sinusitis
____ Bladder/Urinary	____ Gout	____ Skin Disorders
____ Cancer	____ Gum/Teeth	____ Stroke
____ Chest Pain	____ Hayfever	____ Thyroid Problems
____ Colitis	____ Headaches	____ Ulcers
____ Colds/Flu Frequently	____ Heart Disorder	____ Sleep Disorder
____ Diabetes	____ High Blood Pressure	____ Other, please list

Please List and Date any Injuries, Surgeries and Hospitalizations: _____

_____

Family Medical History:

Please state age and current health (or cause and age at death) for each family member.

Father _____

Mother _____

Siblings _____

Other illnesses that run in the family _____

Diet:

Daily Intake of: Water _____, Caffeine _____, Alcohol _____, Tobacco _____,

Breakfast _____

Lunch _____

Dinner _____

Beverages _____ Snacks _____

I, the undersigned, verify that I have insurance with _____ and assign directly to Dr. Stroud all insurance benefits, if any, otherwise payable to me for services rendered. I also understand that Dr. Stroud and/or his staff will help to determine and process insurance claims as best they can but they do not guarantee insurance coverage for services or laboratory tests. I further understand that I am 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.

I also understand that if I cancel of no show with less than 24 hours notice, I will be charged a $45 fee.

Signature: _____ Date: _____