



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.wenatcheeacupuncture.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 health 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-

Naturopathic Medicine · Acupuncture · Nutrition Therapy · Cranio-Sacral Therapy-

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Alcohol/Substance Abuse | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Joint Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Edema | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Liver/Hepatitis | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Bladder/Urinary | <input type="checkbox"/> Gout | <input type="checkbox"/> Skin Disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gum/Teeth | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hayfever | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Colds/Flu Frequently | <input type="checkbox"/> Heart Disorder | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> 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: _____