INTAKE / REFERRAL FORM

Stuart S. Shipe, DOM, P.A.

Today's Date_____

How did you hear about our office_____

PATIENT INFORMATION						
Patient Name			**Home Phone ( )**			
Address			**Cell Phone ( )**			
Address			**Office Phone ( )**			
City	**State**	**Zip**	**SS#**			
Email Address		**DOB**	**Age**	**Ht**	**Wt**	
Marital Status: M S W D	**Sex: M F**	**Occupation**				
Drivers License Number		**State License Issued**				

Must correspondence from this office be sent to you in a sealed "Confidential" envelope? YES NO
Can this office leave telephone voice-mail messages concerning scheduling? YES NO
Can this office send text messages to you related services, special offers, and seminars sponsored by us? YES NO
Can this office email to you related services, special offers, and seminars sponsored by us? YES NO

Please list the persons with whom we may inform about your health condition or treatment	
(Include Family, friends and physicians)	
Name	Phone
Name	Phone
Name	Phone
Name	Phone
If Minor: Legal Guardian's Name (print)	(Signature)

Circle any you have had in the past:

Emphysema	Diabetes	Syphilis	Thyroid Disease	Mumps
Meningitis	Paralysis	Allergies	Rheumatic Fever	Polio
Epilepsy	Measles	Cancer	Heart Disease	Migraines
CVA (stroke)	Poor Veins	Glaucoma	Nervous Disorder	MS
Pneumonia	High Fever	Shingles	High Blood Pressure	HIV/ AIDS
Cataract	Lyme's	TB	Chicken Pox	Hepatitis

Immunizations:

Have you had problems with these? Circle if Yes

Mood	Seeing	Appetite	Numbness	Constipation	Weight
Swelling	Smelling	Sleeping	Mood	Menstruation	Hearing
Stiff Joints	Racing Heart	Breathing	Allergies	Balance	
Dizziness	Digestion	Libido	Skin	Lumps	

Do you have the following condition(s) currently? (Circle)

Pregnancy Bleeding Disorder Pacemaker Cancer Ostomy Shunts
Local Infection Communicable Disease Artificial Joint

How are your dietary habits? Good Fair Poor
Do you exercise routinely? Yes No

I certify that the above statements are true

Signature of Patient

Have you had Acupuncture before? YES NO
By whom
Who is or was your regular doctor?

City State
May we contact them? YES NO
When was your last medical exam?

Any hospitalization or surgery?
Condition Year

Are you taking any medication? YES NO
Specify

1605 NW Federal Hwy Stuart FL, 34994 Office: 772-398-4550 Fax: 772-398-4552