



PATIENT CONFIDENTIAL INFORMATION

Name _____
First Middle Last

Address _____
Street City State Zip

Preferred Phone _____ Email _____
I DO NOT wish to receive occasional educational and promotional notices.

Age _____ Date of Birth _____ Sex _____ Height _____ Weight _____

How did you find out about us? _____

Occupation _____ Employer _____

In case of emergency, call _____
Name Street City Phone

Primary Physician Name _____

FOR ALL PATIENTS: Do you have a pacemaker or other electronic implant? _____ IF YES, SINCE WHEN? _____

FOR FEMALES: Are you pregnant? _____ IF YES, HOW LONG? _____

FOR MINORS: List guardian's name and address

FINANCIAL ARRANGEMENTS

How do you plan to handle your account? (Check one) Cash Check Master Card Visa

CANCELLATION POLICY

The time that is scheduled for you is not available to any other individual. A late cancellation fee equal to the cost of your treatment is charged per occurrence if there is less than 24 hours notice of a cancellation or request to reschedule (unless it is an emergency).

I agree to the aforementioned terms. I assert that, to the best of my knowledge, all information herein is correct and complete. I authorize communication between my acupuncturist and my other medical providers to coordinate my care.

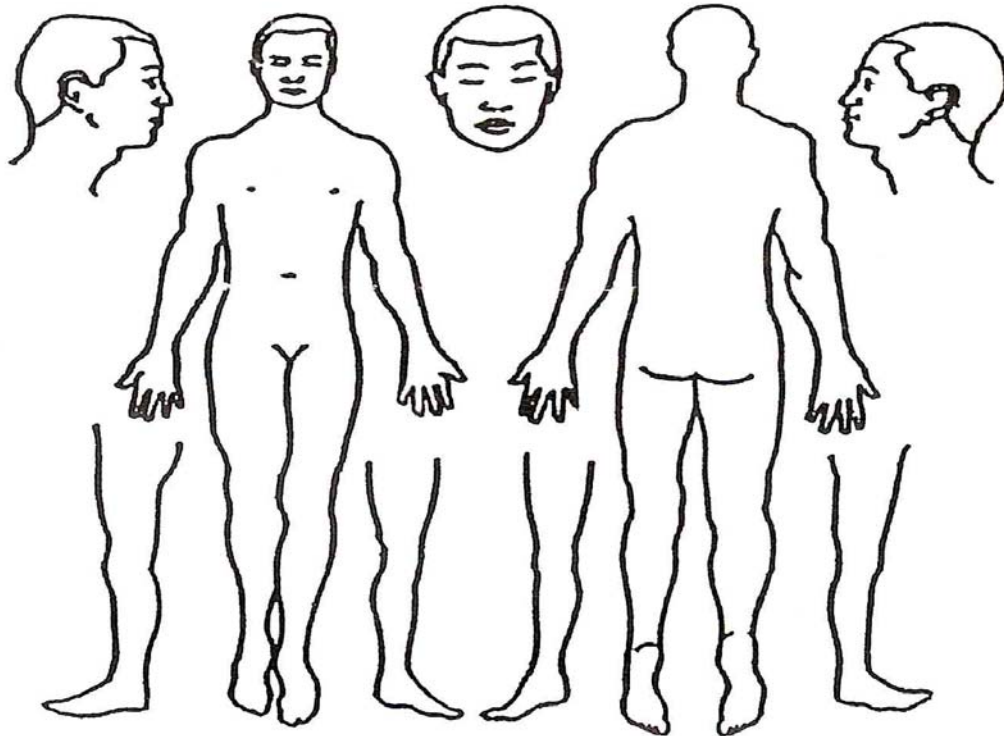
PATIENT'S SIGNATURE _____ DATE: _____
(parent/guardian's signature if patient is minor)

Patient Confidential Health History

Please help me provide you with a thorough evaluation by taking the time to complete this questionnaire carefully. As with all of our correspondence, your answers will be completely confidential. If there is anything that you feel I should know that is not asked, please write it either in the margin or at the bottom of the page. If you have any questions, please don't hesitate to ask.

Have you had acupuncture before? How recently?
In addition to acupuncture treatment, would you like to discuss herbal medicine that may be helpful?
Main problem(s) you would like help with:
How long ago did each problem begin?
To what extent does this problem interfere with ability to function (eg. work, home, sleep, digestion, exercise, sex)?
Have you received a diagnosis from a medical professional? If so, what?
What treatments have you tried (chiropractic, massage, self-treatment like ice/heat/rest)? Does anything help?

Please indicate any painful or uncomfortable areas



Lifestyle Factors

Medications taken within the last two months – *please include vitamins, herbs, etc.*

What do you do for exercise? How often?

Do you restrict your diet in any way? (*vegetarian, no red meat, etc.*)

Approximately how much water do you drink a day?

How much caffeine do you drink?

Do you use tobacco? If so, what kind (cigarettes, cigars, etc.) and how much?

How many alcoholic beverages do you typically drink in a week?

Past Medical History

Significant Illnesses – *please circle and include approx. date*

Cancer Hepatitis Diabetes High Blood Pressure Heart Attack Stroke Seizures Other

Surgeries – *please include approx. date*

Hospitalizations – *please include approx. date and reason*

Significant Trauma (*sports, fractures, falls, auto accidents, etc.*)

Allergies (*medications, foods, chemicals, etc.*)

Family Medical History

Cancer Hepatitis Diabetes High Blood Pressure Heart Attack
 Stroke Seizures Asthma Allergies Other _____

Please check any symptoms that you have had in the last 3 months (*circle any that are severe*)

General

- | | | |
|---|--|--|
| <input type="checkbox"/> sweating easily during the day | <input type="checkbox"/> chills | <input type="checkbox"/> fevers |
| <input type="checkbox"/> night sweats | <input type="checkbox"/> poor sleep | <input type="checkbox"/> weight loss |
| <input type="checkbox"/> bleed or bruise easily | <input type="checkbox"/> fatigue | <input type="checkbox"/> weight gain |
| <input type="checkbox"/> change in appetite | <input type="checkbox"/> peculiar tastes or smells | <input type="checkbox"/> undiagnosed pain |
| <input type="checkbox"/> sudden energy drop (what time of day?) _____ | <input type="checkbox"/> cravings (foods, other) _____ | <input type="checkbox"/> strong thirst (for hot or cold drinks?) |
| | | other: _____ |
-

Skin and Hair

- | | | |
|----------------------------------|---|---|
| <input type="checkbox"/> rashes | <input type="checkbox"/> eczema | <input type="checkbox"/> psoriasis |
| <input type="checkbox"/> hives | <input type="checkbox"/> ulcerations, furuncles, etc. | <input type="checkbox"/> loss of hair |
| <input type="checkbox"/> itching | <input type="checkbox"/> pimples – where? _____ | <input type="checkbox"/> change in skin or hair texture |
| | <input type="checkbox"/> recent moles | other: _____ |
-

Head, eyes, ears, nose, and throat

- | | | |
|---|--|--|
| <input type="checkbox"/> earaches | <input type="checkbox"/> headaches/migraines | <input type="checkbox"/> dizziness/vertigo |
| <input type="checkbox"/> ringing in the ears | <input type="checkbox"/> blurry vision | <input type="checkbox"/> sinus pressure |
| <input type="checkbox"/> plugged feeling in ears | <input type="checkbox"/> floaters (spots in front of eyes) | <input type="checkbox"/> nose bleeds |
| <input type="checkbox"/> hearing loss (temporary/permanent) | <input type="checkbox"/> itchy eyes | <input type="checkbox"/> sores on lips or tongue |
| | <input type="checkbox"/> sinus infections | <input type="checkbox"/> teeth/jaw clenching or grinding |
-

Cardiovascular, circulatory

- | | | |
|-------------------------------------|---|---|
| <input type="checkbox"/> chest pain | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> low blood pressure |
| <input type="checkbox"/> fainting | <input type="checkbox"/> cold hands and/or feet | <input type="checkbox"/> swelling/edema |
| | <input type="checkbox"/> lightheadedness | other: _____ |
-

Respiratory

- | | | |
|---|--|-----------------------------------|
| <input type="checkbox"/> pain with deep breath | <input type="checkbox"/> cough | <input type="checkbox"/> asthma |
| <input type="checkbox"/> seasonal/other allergies | <input type="checkbox"/> chest tightness | <input type="checkbox"/> sneezing |
| | <input type="checkbox"/> phlegm – color: _____ | other: _____ |
-

Digestive

- | | | |
|------------------------------------|---|--|
| <input type="checkbox"/> heartburn | <input type="checkbox"/> chronic bad breath | <input type="checkbox"/> rectal pain/itching |
| <input type="checkbox"/> gas | <input type="checkbox"/> nausea | <input type="checkbox"/> abdominal pain/cramps |
| <input type="checkbox"/> bloating | <input type="checkbox"/> vomiting | <input type="checkbox"/> blood in stool |
| <input type="checkbox"/> belching | <input type="checkbox"/> diarrhea | <input type="checkbox"/> mucus in stool |
| | <input type="checkbox"/> constipation | <input type="checkbox"/> hemorrhoids |
-

other: _____

Genito-Urinary

- | | | |
|---|--|---|
| <input type="checkbox"/> difficulty urinating | <input type="checkbox"/> pain upon urination | <input type="checkbox"/> urgent or frequent urination |
| <input type="checkbox"/> decrease flow | <input type="checkbox"/> sores on genitals | <input type="checkbox"/> kidney stones |
| <input type="checkbox"/> blood in urine | <input type="checkbox"/> waking to urinate | <input type="checkbox"/> impotence |
| | <input type="checkbox"/> genital pain | other: _____ |
-

Neurological / Psychological

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> poor memory | <input type="checkbox"/> seizures | <input type="checkbox"/> lack of coordination/loss of balance |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> areas of numbness or paralysis | <input type="checkbox"/> quick temper |
| | <input type="checkbox"/> easily susceptible to stress | <input type="checkbox"/> depression |

Have you ever taken medication for any condition in this section? When and which?

other: _____

Gynecological

- | | | |
|---|-----------------------------------|---|
| <input type="checkbox"/> irregular periods | age of first menses: _____ | # pregnancies: _____ |
| <input type="checkbox"/> painful periods | duration of typical period: _____ | # live births (year?): _____ |
| <input type="checkbox"/> bleeding between periods | duration of cycle: _____ | # premature births (year?): _____ |
| <input type="checkbox"/> breast issues: _____ | <input type="checkbox"/> clots | # miscarriages: _____ |
| <input type="checkbox"/> vaginal discharge | <input type="checkbox"/> cramping | # abortions: _____ |
| <input type="checkbox"/> vaginal sores | date of last PAP: _____ | <input type="checkbox"/> menopause – age? _____ |

Have you ever taken birth control pills? When and for how long?

Other premenstrual & menstrual symptoms – (bloating, breast tenderness, irritability, mood swings, fatigue, loose stool, poor coordination, acne...):

other: _____

Comments: *Please list any other issues you would like to discuss.*