New Patient Contact Information and Health History

INFORMATION ABOUT YOURSELF

First Name_____Last Name_____

Today's Date_____Date of Birth_____ Current Age_____

Mailing Address_____

City_____State_____Zip_____

Phone_____Email_____

Emergency Contact Name and Number_____

Have you ever had acupuncture before?_____

PATIENT HEALTH HISTORY

What is the primary reason for attending community acupuncture?

_____

_____

Medications you are presently taking:

_____

_____

Allergies: _____

Please list your top five major health concerns in order of importance:

1._____

2. _____

3. _____

4. _____

5. _____

Do you have or have you ever had:

[ ]Arthritis [ ]Asthma [ ]Anemia [ ]Heart Trouble [ ]Cancer [ ]Diabetes
[ ]Epilepsy [ ]Stroke [ ]Kidney or Bladder Trouble [ ]Gallstones [ ]Ulcers
[ ]Fatigue/Fibromyalgia [ ]High Blood Pressure [ ]Hepatitis/Jaundice
[ ]Sudden Weight Loss [ ]Sudden Weight Gain [ ]HIV+

Other:_____

Family History:(Has any member of your family had any other serious health problem) _____

If yes, which member & what did they have?

_____

Energy Level: Please rank your overall energy level on a scale from 1 to 10:

0 1 2 3 4 5 6 7 8 9 10

Do you experience an energy slump any time of the day? When?_____

Stress: What causes it?

_____

_____

Sweating:
[ ]Night Sweats [ ]Excessive Sweating [ ]Sweating with Slight Exertion [ ]Doesn't Sweat

Circulation:
[ ]Hot areas?_____[ ]Cold areas?_____ [ ]Cold limbs [ ]Bruises easily
[ ]Bleeds easily Other:_____

Skin:
[ ]Dry itchy [ ]Moist/Clammy [ ]Frequent rashes [ ]Burning [ ]Hair thinning [ ]Acne
[ ]Dry scalp [ ]Bruises easily [ ]Hives Other:_____
Scars:_____

Sleep (Circle all that apply): trouble falling asleep trouble staying asleep excessive dreaming
Other: _____How many hours do you sleep per night?_____

Head:
Headaches/Migraines (what area?)_____
[ ]Dizzy [ ]Memory loss [ ]Loss of balance Other :_____

Eyes:
[ ]Eye pain [ ]Blurred vision [ ]Dry eyes [ ]Darkness under eyes
Other: _____

Ears:
[ ]Poor hearing [ ]Earaches [ ]Ear infections [ ]Ear ringing
Other: _____

Nose:
[ ]Frequent nose bleeds [ ]Sinus issues [ ]Frequent colds
Other:_____

Throat:
[ ]Sore Throat [ ]Difficulty swallowing [ ]Swollen tongue [ ]Hoarseness [ ]Jaw Problems
Other: _____

Chest:
[ ]Hard to breathe [ ]Wheezing [ ]Shortness of breath [ ]Pain/pressure in chest
[ ]Palpitations [ ]Persistent cough [ ]Coughing blood [ ]Coughing phlegm
Other:_____

Bowels:
[ ]Diarrhea [ ]Constipation [ ]Bloody stools [ ]Black stools [ ]Mucus in stools
[ ]Hemorrhoids [ ]Lower bowel gas [ ]Stools have foul odor [ ]Colon problems
Number of bowel movements a day?_____

Urine:
Color:_____Amount:_____
[ ]Frequent Urination [ ]Difficulty urinating [ ]Pain or burning [ ]Waking to urinate
[ ]Frequent infections [ ]Water retention [ ]Strong smelling urine [ ]Blood in urine

Musculoskeletal:
Pain in: [ ]Neck [ ]Shoulder [ ]Between Shoulders [ ]Arms/Wrists [ ]Hands/Fingers [ ]Hip
[ ]Knee [ ]Big Toe [ ]Upper Back [ ]Weak Ankles [ ]Mid Back [ ]Stiff all over
[ ] Lower Back [ ]Sciatica [ ]Tingling in Feet [ ]Bones sore/painful [ ]Muscle spasm/cramps
[ ]Loss of grip [ ]Loss of feeling inHands/Feet [ ]Swollen Knees/Elbows
[ ]Leg cramps at night [ ]Painful Joints [ ]Weakness in Legs [ ]Bursitis
Other:_____

Neurological:
[ ]Nervousness [ ]Depressed [ ]Easily angered [ ]Easily irritated [ ]Frequent crying
[ ]Worry/anxiety [ ]Mood swings [ ]Poor coordination [ ]Memory loss [ ]Muscle weakness
[ ]Poor concentration [ ]Feel weak and shaky [ ]Suicidal [ ]Seizures [ ]Tremors [ ]Nerve pain
[ ]Numbness/tingling in limbs [ ]Shingles
Other: _____

Females:
Last monthly period _____Last PAP test_____
Form of birth control_____Age started menses_____
Age stopped_____Color of menses/clots:_____
No. Pregnancies_____ No. Deliveries_____No. Miscarriages_____
[ ]Water retention [ ]Low or no sex drive [ ]Hot flashes [ ]Food cravings [ ] Mood changes
[ ]Miss periods [ ]Painful Breasts Discharge:[ ]Yellow [ ]White [ ]Itching [ ]Thick [ ]Odor

Males:
[ ]Low or no sex drive [ ]Impotence [ ]Ejaculation causes pain [ ]Discharges
[ ]Premature ejaculation [ ]Pain or burning while urinating [ ]Prostate trouble

Appetite:
[ ]Excessive appetite [ ]Poor appetite [ ]Tired/weak if meal is missed [ ] Excessive thirsty
[ ]Never thirsty Specific food cravings:_____

Digestion:
[ ]Stomach gas [ ]Lower bowel gas [ ]Heartburn [ ]Burning/belching [ ]Stomach pain
[ ]Stomach cramps [ ]Nausea [ ]Vomiting [ ]Bad breath [ ]Sores in mouth [ ]Weight gain
[ ]Weight loss [ ]Bitter/sour taste in mouth [ ]Food Allergies [ ]Abdominal bloating
Other: _____

Nutrition and Lifestyle:
Favorite foods:

Do You: [ ]Skip breakfast [ ]Eat snacks during the day [ ]Eat a hearty breakfast
How many meals a day do you eat? _____ When is your biggest meal?_____
How many glasses of water do you drink a day?____ How many alcoholic drinks per week:____
[ ]Smoker No. of packs per day: _____How many years?_____

Do you: [ ]Eat raw fruits and vegetables daily [ ]Eat frequently between meals
[ ]Drink juice, milk or other drinks instead of water when thirsty [ ]Always add salt
[ ]Eat meat or dairy products 2 or more times a day [ ]Eat the same foods almost every day
[ ]Eat when you are not hungry [ ]Eat until you feel full [ ]Occasionally go on a crash diet
Describe your typical meals for the day:

Breakfast_____

Lunch_____

Dinner_____

Is there anything else you would like us to know about you?_____

_____

THANK YOU!