Acupuncture & Oriental Medicine New Patient Information

All information is confidential unless you grant permission to release it. Please print and complete all information.

Name: _____ Date:___ /_____/_____

Date of Birth: ____/_____/_____ Gender: M / F Age: _____

Address: _____
City: _____ State: _____ Zip:_____
Home Phone: _____ Cell Phone: _____
Email: _____

- Occupation:_____
- How did you hear about us?

  _____

Emergency Contact:

Name _____ Phone number _____ Relationship _____

- Are you currently under the supervision of a physician? Yes / No

Physician's Name: _____
Phone Number: _____

- Is this your first acupuncture treatment? Yes /No

If no, what is the name of your previous acupuncturist? _____

- Reason for today's visit:

  _____

Acupuncture & Oriental Medicine Confidential Health History

Name _____ Date ___/____/____

- Please mark a **C** in the space next to each condition that you have **recently** experienced (in the past month) or are **currently** experiencing.
- Please mark **P** in the space next to each condition that you have experienced **in the past**.
- If you have **never** experienced a condition, please leave the space **blank**.

TEMPERATURE REGULATION

____I usually feel more hot than cold.
____I usually feel more cold than hot.
____Fever/Chills
____Night Sweats
____Hot Flashes
____Excessive Perspiration
____Lack of Perspiration
____Spontaneous Sweating
____Cold hands/feet/fingers/toes (circle all applicable)
____Hot hands/feet/palms/soles (circle all applicable)

HEAD

____Tension Headache
____Sinus Headache
____Migraine Headache
____Hair Loss
____Dry/Flaky Scalp
____Other

EYES

____Dryness
____Redness
____Itching/Pain
____Blurred/Double Vision
____Tearing
____Itching/Pain
____Cataracts
____Glaucoma
____Others

EARS

____Ringing
____Hearing Loss
____Itching/Pain
____Others

NOSE

____Bleeding
____Congestion
____Runny Nose (clear)
____Runny Nose (yellow)
____Loss of Smell

MOUTH

____Dryness/Excessive Thirst
____Bad Taste in Mouth (describe) _____
____Sores/Pain
____Bleeding Gums
____Loss of Taste
____Dental Problems (describe) _____
____Other

THROAT

____Dryness
____Itching/Soreness/Pain
____Difficulty Swallowing
____Hoarseness
____Tonsillitis
____Other

Name _____ Date ___/____/____

CHEST

____Distention/Tightness
____Pain
____Hot/Burning Sensation
____Others

BREAST

____Distention/Pulling
____Tenderness/Pain
____Nodule/Lump
____Fibrocystic Breasts
____Discharge
____Others

EPIGASTRIC (LOWER RIB) AREA

____Distention/Pulling Sensation
____Pain
____Hot/Burning Sensation
____Cold Sensation
____Other

HEART/CARDIOVASCULAR

____***Pacemaker**
____Poor Circulation
____Pain Over Heart
____Irregular Heartbeat
____Palpitations
____High Blood Pressure
____Low Blood Pressure
____Dizziness
____Fainting
____Heart Attack
____Ankle Swelling
____Varicose Veins
____Rheumatic Fever
____Stroke
____Blood Clots
____Anemia
____Bleeding disorders
____Other

LUNG/RESPIRATORY

____Difficulty Breathing
____Shortness of Breath
____Dry Cough
____Productive Cough
____Phlegm
____Coughing Blood
____Pneumonia
____Bronchitis
____Emphysema
____Tuberculosis
____Runny Nose
____Postnasal Drip
____Seasonal Allergies
____Frequent Colds (# per year) ___
____Other

Name _____ Date ___/____/____

DIGESTIVE/GASTROINTESTINAL

____Poor Appetite
____Excessive Appetite
____Feel Satisfied After Meals
____Get Hungry Quickly After Meals
____Nausea
____Vomiting
____Vomiting Blood
____Acid Regurgitation
____Ulcer
____Hernia
____Diarrhea
____Loose Stool
____Undigested Food in Stool
____Mucus in Stool
____Blood in Stool
____Constipation
____Hemorrhoids
____Appendicitis
____Liver Cirrhosis
____Hepatitis
____Jaundice
____Gallstones
____Gallbladder surgery: date_____
____Other

Abdomen
____Swelling
____Distention or Gas
____Pain
____Belching
____Coldness
____Cramping

Frequency of Bowel Movements:

_____ time(s)/ every _____ day(s)

Which of the following types of foods do you usually crave? Please circle.
1. salty **2.sweet** **3.spicy** **4.fatty**

List **3-5 foods** you eat almost **every day:**

1_____2_____3_____4_____5_____

Name _____ Date ___/____/____

NEURO-MUSCULOSKELETAL

____Neck Stiffness/Pain
____TMJ
____Pain Between Shoulders
____Arm/Wrist/Hand Pain
____Numbness/Tingling: location(s)_____
____Mid Back Pain
____Low Back Pain
____Scoliosis
____Bulging/Herniated Disk: location(s)_____
____Pinched Nerve: location_____
____Sciatica
____Knee Pain
____Pain in Calf when walking
____Ankle Pain
____Foot Pain
____Gout
____Osteoporosis
____Fracture(s) location(s)_____
____Tendonitis: location(s)_____
____Osteoarthritis: location(s)_____
____Rheumatoid Arthritis location(s)_____
____Swollen Joints location(s)_____
____Painful Joints location(s) _____
____Muscle Aches/Soreness location(s) _____
____Muscle Weakness: location(s)_____
____Muscle Twitching: location(s) _____
____Tremors: location(s)_____
____Convulsions
____Epilepsy
____Parkinson's Disease
____Multiple Sclerosis

NEURO-EMOTIONAL

____Anxiety
____Depression
____Insomnia
____Frequent, Vivid Dreams
____Nightmares
____Irritability
____Hot Temper
____Mood Swings
____Sighing Frequently
____Tension/Stress
____Headaches
____Anorexia/Bulimia
____Suicidal Thoughts

SKIN

____Itching
____Rashes
____Oily Skin
____Dry Skin
____Acne
____Slow Healing
____Eczema
____Psoriasis
____Change in Moles
____Skin Cancer
____Bruise Easily
____Other

Name _____ Date ___/____/____

GENITOURINARY

____Frequent Urination
____Excessive Urination
____Difficulty Starting Urination
____Painful/Burning Urination
____Nighttime Urination
# of time(s)/night _____
____Inability to hold urine
____Leakage of urine when coughing or sneezing
____Blood in Urine
____Urinary Tract Infection
____Kidney Stones
____Kidney Disease
____Sexual Difficulty_____
____Sexually Transmitted Diseases:
date treated_____

GENERAL

____Loss of Sleep:
# of hrs of sleep per night____
____Difficulty Falling Asleep
____Difficulty Staying Asleep
____Fatigue
____Fibromyalgia
____Weight Loss or Gain
____Diabetes
____Hypothyroid
____Hyperthyroid
____Cancer: Type_____
____Benign Tumor
Location: _____
____AIDS/HIV risk factors
____Hepatitis
____Typhoid Fever
____Tuberculosis
____High Cholesterol

ACCIDENTS/TRAUMA/INJURIES

____Motor Vehicle Accidents: Date_____
____Other Trauma/Accidents/Injuries:
(Describe)_____

HOSPITALIZATIONS/SURGERIES

List dates and reasons:
1._____

2._____

LIFESTYLE CHOICES

____Smoking: ____# cigarettes/week
____Caffeine: ____cups/day
____Alcohol: ____#drinks/week
____Recreational Drug Use _____#times/week
____Exercise: ____days/week Type of exercise _____

Name _____ Date ___/____/____

MEN ONLY

____Testicular Swelling/Pain
____Discharge from Penis
____Male Infertility
____Prostate Cancer
____Testicular Cancer
____Erectile Dysfunction
____Prostate Hypertrophy
____Date of last PSA test _____

WOMEN ONLY

____ I am **pregnant.** Due date: _____
____There is a possibility that I am **pregnant.**

Menstrual Cycle

- How old were you when you first started menstruation? _____
- Are you still having regular menstrual cycles? Yes / No
- Date your last period began? _____
- Menstrual Pain/Cramps (mark all that apply) ____Before _____During _____After
- Low Back Pain (mark all that apply)____Before _____During _____After
- Color/Quality of Menstrual Blood (mark all that apply)
  ____Pale Pink ____Red ____Purple ____Brown ____Clots

____Premenstrual Bloating/Abdominal Distention
____Premenstrual Headaches
____Premenstrual Breast Tenderness
____Premenstrual Gas
____Premenstrual Moodiness/Irritability/Depression
____Mid-cycle lower abdominal pain
____Bleeding between periods
____Fatigue before, during or after period
____Vaginal Discharge
____Recurring Yeast Infections
____Heavy Menstrual Bleeding
____Female Infertility
____Polycystic Ovarian Syndrome
____Endometriosis
____Uterine Fibroids
____Vaginal Burning/Itching
____Vaginal Pain
____Vaginal Dryness
____Hot Flashes or Night Sweats

Date of last pap test _____ Date of last mammogram_____
Number of Births_____ Number of Miscarriages_____

CHILDHOOD DISEASES

____Mumps ____Measles ____Chicken Pox ____Meningitis ____Polio
____Mononucleosis ____Rheumatic Fever ____Whooping Cough

Name _____ Date ___/____/____

FAMILY HEALTH HISTORY Check the appropriate box.

Disease	Mother	Father	Brother	Sister	Grandma	Grandpa	Uncle	Aunt
Diabetes								
Thyroid Disease								
Stroke								
Kidney Disease								
High Blood Pressure								
Heart Disease								
Cancer (type)								
Obesity								
Allergies								
Alcoholism								

VITAMINS & HERBAL SUPPLEMENTS

Vitamin/Herb	Dose	Frequency	Reason	Allergies

PRESCRIPTION MEDICATIONS

Medication	Dose	Frequency	Reason	Allergies

Acupuncture & Oriental Medicine
Information & Informed Consent

Acupuncture Information

I have been informed by the practitioner that acupuncture is performed by the insertion through the skin of pre-sterilized, disposable acupuncture needles. A treatment may also consist of the application of heat and/or electrical stimulation to the skin at certain points on the body and/or the application of a tool on the surface of the skin to promote circulation and reduce pain and inflammation.

Benefits and Risks

The benefits and risks of receiving acupuncture and oriental medicine treatments have been explained to me. As a result, I understand the following information:

Certain side-effects, although extremely rare, may result from receiving acupuncture and/or oriental medicine modalities including but not limited to:

1) minor bruising
2) temporary dizziness, light-headedness, or achy, flu-like sensation
3) broken needles
4) pain or tenderness around the points of needle insertion
5) very slight risk of infection
6) minor burns

Patient Name:

_____

Please Print

Patient's Signature: _____ Date_____/_____/_____