Patient Information

Name:_____ Date: _____

Address: _____ Phone: _____

_____ Gender: _____

Birth Date: _____ Age: _____

Email address (optional) _____

Referred here by: _____

Emergency Contact: _____ Telephone #: _____

Relationship: _____

Have you ever had acupuncture before? Y / N

What health issue(s) would you like to be addressed? _____

_____

Are you presently being treating for any medical conditions? Please describe. _____

_____

Please briefly describe any chronic pain. _____

What treatment have you been using for relief of this pain? _____

_____

Do you have other health concerns? _____

Are you a vegetarian / vegan? **Y / N**

Do you drink coffee? **Y** Frequency _____ **N**

Please list any food or drug allergies: _____

Do you exercise regularly? **Y** Type of exercise _____ **N**

Please list any vitamins, herbs, or medications you are currently taking:_____

_____

_____

Previous Pregnancies

Living_____ Ectopic_____ Miscarriages_____ Induced Abortions_____ Total_____

Head and Neck

Past	current	
☐	☐	Blurred vision
☐	☐	Visual changes
☐	☐	Poor night vision
☐	☐	Visual spots
☐	☐	Cataracts
☐	☐	Eye discharge
☐	☐	Nose bleeds
☐	☐	Sinus infection
☐	☐	Nasal allergies
☐	☐	Sore throat
☐	☐	Swollen glands
☐	☐	Teeth grinding
☐	☐	Ear infection
☐	☐	Ringing of ears
☐	☐	Poor hearing

Gastro-Intestinal

Past	current	
☐	☐	Bad breath
☐	☐	Belching
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Indigestion
☐	☐	Pain/cramps
☐	☐	Gas/bloating
☐	☐	Gallbladder disorder
☐	☐	Constipation
☐	☐	Hemorrhoids
☐	☐	Rectal Pain
☐	☐	Diarrhea
☐	☐	Bloody stools

Cardiovascular

Past	current	
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Blood clots
☐	☐	Palpitations
☐	☐	Chest Pain
☐	☐	Irreg. heart beat
☐	☐	Edema
☐	☐	Valve prolapse
☐	☐	Pacemaker

Respiratory

Past	current	
☐	☐	Asthma
☐	☐	Bronchitis
☐	☐	Frequent colds
☐	☐	Pneumonia
☐	☐	Cough
☐	☐	Short of breath
☐	☐	COPD
☐	☐	Tuberculosis

Genito-Urinary

Past	current	
☐	☐	Painful urination
☐	☐	Frequent urination
☐	☐	Bloody urine
☐	☐	Urgency
☐	☐	Frequent UTI
☐	☐	Kidney stones
☐	☐	Kidney disease
☐	☐	Leaky bladder

Ortho-Neuromuscular

Past	current	
☐	☐	Pain/tightness
☐	☐	Numbness
☐	☐	Seizures
☐	☐	Tremors
☐	☐	Paralysis

Skin

Past	current	
☐	☐	Rashes/hives
☐	☐	Itching
☐	☐	Dryness
☐	☐	Eczema
☐	☐	Psoriasis
☐	☐	Acne
☐	☐	Tumors/lumps

Use history

Past	current	
☐	☐	Tobacco
☐	☐	Marijuana
☐	☐	Alcohol
☐	☐	Cocaine/crack
☐	☐	Speed
☐	☐	Heroin
☐	☐	Pain meds

Female

Past	current	
☐	☐	Vaginal infection
☐	☐	Genital pain/itch
☐	☐	Genital lesions
☐	☐	Genital discharge
☐	☐	PID
☐	☐	Abnormal PAP
☐	☐	Irregular menses
☐	☐	Painful menses
☐	☐	PMS
☐	☐	Abnormal bleeding
☐	☐	Breast lumps

Male

☐	☐	Genital lesions
☐	☐	Genital pain/itch
☐	☐	Genital discharge
☐	☐	Impotence

Psychological

Past	current	
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Insomnia
☐	☐	Bipolar disorder
☐	☐	Stress
☐	☐	Irritability
☐	☐	Substance abuse
☐	☐	Eating disorder
☐	☐	Sexual abuse
☐	☐	Physical abuse

Positive Test Results for:

Past	current	
☐	☐	HIV
☐	☐	Hepatitis
☐	☐	Gonorrhea
☐	☐	Syphilis
☐	☐	Genital warts
☐	☐	Herpes