



Confidential Patient Information Sheet

Patient Information

Name _____ SSN _____ Date _____
Address _____ City _____ State _____
Zip _____ Home phone _____ Work phone _____ Cell _____
Email _____ Have you had acupuncture before? Yes No
Height _____ Weight _____ Age _____ Sex: Male Female Date of birth _____
Occupation _____ Employer _____
Annual Income Range: Less than \$49,000 \$50,000 to \$99,000 \$100,000 to \$249,000 \$250,000 + Retired
In emergency notify (name): _____ Emergency phone number: _____
Marital Status: Single Married Domestic Partner Divorced Widowed Separated
Number of children: _____ Ages of children: _____ Number who live with you: _____
Others living with you: _____
Primary Care Doctor: _____ Last seen: _____
How did you hear about Acupuncture Associates: Yellow Pages Article A Talk Brochure
 Business Card Web site Newspaper Referred by: _____

Medical History

Reason for your visit here today: _____
Are you being treated for this condition by anyone else: Yes No
If Yes, who? _____ Phone number: _____
Has this condition been diagnosed by a MD? Yes (Diagnosis: _____) No
Have these treatments helped? Yes Somewhat Not much Not at all
How does this condition affect you? _____
How long have you had this condition? _____
Do you currently have any infectious disease? Yes No Possibly
If Yes, please identify: HIV+ Hepatitis B Hepatitis C Flu / Cold Streptococcus
 Mononucleosis Tuberculosis Other: _____
Known or suspected allergies: _____
Childhood diseases you have had: Chicken Pox Measles Mumps Rheumatic Fever Diphtheria
 Scarlet Fever Other _____
Physical or Emotional Traumas / Accidents / Hospitalizations / Surgeries in the past 10 years:
Reason _____ Date / Year(s) _____

Health Inventory

Cardiovascular Conditions: <input type="checkbox"/> Heart Disease <input type="checkbox"/> A Pacemaker <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Stroke <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Edema	Emotional / Mental: <input type="checkbox"/> Clinical Depression <input type="checkbox"/> Mild Depression <input type="checkbox"/> ADD or ADHD <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Mood Swings <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Nervousness <input type="checkbox"/> Anxiety <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Dementia	Energy & Immunity: <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> General Fatigue <input type="checkbox"/> Slow Wound Healing <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Chronic Infections <input type="checkbox"/> Frequent Allergies	Respiratory: <input type="checkbox"/> Pneumonia <input type="checkbox"/> Asthma <input type="checkbox"/> Frequent Common Colds <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Emphysema <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Pleurisy <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Shortness of Breath
Musculo-Skeletal: <input type="checkbox"/> Neck / Shoulder Pain <input type="checkbox"/> Muscle Spasms / Cramps <input type="checkbox"/> Arm Pain <input type="checkbox"/> Upper Back Pain <input type="checkbox"/> Mid Back Pain <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Leg Pain <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Joint Pain	Head, Eye, Ear, Nose & Throat: <input type="checkbox"/> Impaired Vision <input type="checkbox"/> Eye Pain / Strain <input type="checkbox"/> Glaucoma <input type="checkbox"/> Glasses / Contacts <input type="checkbox"/> Tearing / Dryness <input type="checkbox"/> Impaired Hearing <input type="checkbox"/> Ear Ringing <input type="checkbox"/> Earaches <input type="checkbox"/> Ear Infections <input type="checkbox"/> Headaches <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Teeth Grinding <input type="checkbox"/> Frequent Sore Throats <input type="checkbox"/> TMJ / Jaw Problems <input type="checkbox"/> Hay Fever	Genito-Urinary Tract: <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Painful Urination <input type="checkbox"/> Dribbling Urination <input type="checkbox"/> Frequent UTI <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Discharge <input type="checkbox"/> Incontinence Neurological <input type="checkbox"/> Vertigo / Dizziness <input type="checkbox"/> Paralysis <input type="checkbox"/> Numbness / Tingling <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Seizures / Epilepsy <input type="checkbox"/> Dyslexia	Gastrointestinal: <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Changes in Appetite <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Epigastric / Abdominal Pain <input type="checkbox"/> Passing Gas <input type="checkbox"/> Heart Burn <input type="checkbox"/> Belching <input type="checkbox"/> Gall Bladder Disease <input type="checkbox"/> Gall Bladder Stones <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea
Endocrine: <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Diabetes Type I <input type="checkbox"/> Diabetes Type II <input type="checkbox"/> Night Sweats <input type="checkbox"/> Unusual Sweating <input type="checkbox"/> Feeling Hot or Cold	Other: <input type="checkbox"/> Cancer Type: _____ <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Lupus <input type="checkbox"/> Candida <input type="checkbox"/> Anemia <input type="checkbox"/> Rashes <input type="checkbox"/> Eczema / Hives <input type="checkbox"/> Cold Hand / Feet <input type="checkbox"/> Hemophilia <input type="checkbox"/> Thin / Graying hair	Liver Conditions: <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C	Men Only: <input type="checkbox"/> Impotence <input type="checkbox"/> Vasectomy Date: _____ <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Testicular Pain / Redness / Swelling <input type="checkbox"/> Low libido <input type="checkbox"/> Excessive libido <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Seminal emissions

Women Only:

Are you pregnant right now? Yes No Trying Maybe Method of Birth Control: _____

Age at first period: _____ Date of last menses: _____ Age at menopause: _____

Typical length of menses (days): _____ Typical length of cycle (from 1st day to 1st day of menses): _____

Number of Pregnancies: _____ Births: _____ Abortions: _____ Miscarriages: _____

Hysterectomy: Yes No Date: _____

Check all that apply: Low libido Excessive libido Painful Intercourse Clotting Painful Periods Heavy Flow Scanty Flow Bleeding Between Cycles Irregular Cycles Vaginal Discharge Breast Lumps / Tenderness Nipple Discharge Infertility Menopausal Symptoms Premenstrual Problems

Medications

Please list all prescription and over the counter medications you are currently taking:

Drug Name	Reason for taking	For how long	Dose	Frequency
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list all supplements and herbs you are currently taking:

Supplement	Reason for taking	Potency	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Lifestyle

(Daily amount used within the past 2 months)

Tobacco: Yes No Amount: _____ Alcohol: Yes No Amount: _____

Coffee: Yes No Amount: _____ Recreational Drugs: Yes No Amount: _____

Do you feel at or near your ideal weight? Yes No

Do you feel you have enough energy? Yes No Are you vegetarian or vegan? Yes No

Best time of day: _____ Worst time of day: _____

Favorite Season: _____ Hours of sleep / night: _____

Do you feel rested after a nights sleep? _____ Do you remember your dreams? _____

Typical day's meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks / Other: _____

Food cravings: _____

Religion or other spiritual practice: _____

Hobbies or other recreation: _____

What kind of physical exercise you do regularly? _____

Hours of television watched per week? _____ Hours of work per week? _____

Highest level of education completed? High School Bachelors Masters Doctorate Other

How would you rate your current stress level? Extreme Very High High Moderate Low

Emotions / Relationship

Number of biological Brothers: _____ Sisters: _____ Were you adopted? Yes No

Your place in the birth sequence#: _____

Did you feel safe and nurtured as a child? Always Usually Sometimes Never

What would you characterize as your predominate emotion right now? Anxiety / Worry Anger Grief
 Fear / Dread Depression Melancholy Happiness Contentment Joy Numbness / Apathy
 Other: _____

Do you enjoy your work? Yes Usually Sometimes Rarely No

Why or why not? _____

Do you feel you have a higher purpose for your life? Yes Usually Sometimes Rarely No

Do you feel safe in your current significant relationship(s)? Always Usually Sometimes Never

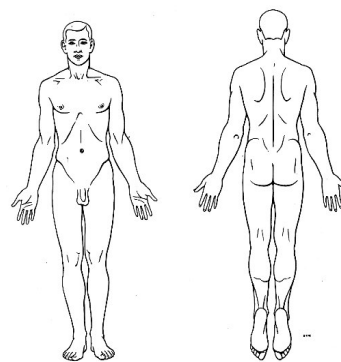
Do you feel nurtured in your current significant relationship(s)? Always Usually Sometimes Never

Are you happy with your current significant relationship(s)? Always Usually Sometimes Never

Are you satisfied with your sex life? Yes Usually Sometimes Rarely No

If you were guaranteed of success and money and time were not obstacles, what would you like to do with your life? _____

Please feel free to express any concerns or thoughts you feel may be relevant to your health below: Use the diagram if desired.



The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Acupuncture Associates **48** hours prior to any cancellations or changes to my appointment times and that if I do not I **will** be charged for the appointment.

X Signed: _____ Date: _____

Parent / Guardian (if applicable) _____

Would you like to receive a free email newsletter? Yes No