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PERSONAL INFORMATION **TODAY'S DATE:**

NAME:
ADDRESS
HEIGHT: WEIGHT: DATE OF BIRTH: AGE: GENDER:
PHONE: HOME MOBILE WORK
EMAIL ADDRESS:
EMERGENCY CONTACT:
STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER:
NUMBER OF CHILDREN & AGES:
REFERRED BY:
HAVE YOU RECEIVED ACUPUNCTURE BEFORE? ☐ YES ☐ NO IF YES, WHEN AND FOR WHAT PURPOSE?

OCCUPATIONAL INFORMATION

STATUS: ☐ ***FULL TIME*** ☐ ***PART TIME*** ☐ ***SELF EMPLOYED*** ☐ ***RETIRED*** ☐ ***UNEMPLOYED*** ☐ ***STUDENT*** ☐ ***OTHER:***
EMPLOYER NAME:
EMPLOYER ADDRESS:
EMPLOYER PHONE:
OCCUPATIONAL STRESS (PHYSICAL/CHEMICAL/PSYCHOLOGICAL)
AVERAGE HOURS OF WORK/STUDY PER WEEK:

PHYSCIAN INFORMATION

PRIMARY DOCTOR: PHONE:
ADDRESS:
DATE OF LAST VISIT:

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY
PHONE
POLICY HOLDER"S NAME
POLICY #/ID # GROUP #
PRIMARY INSURANCE ADDRESS:

MISSED APPOINTMENT POLICY

If you need to change or cancel your appointment please do so with 24 hours notice. Failure to do so will result in being charged full price for missed appointment.

☐ I understand cancellation policy.

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GENERAL HEALTH INFORMATION

WHAT IS YOUR INTENTION FOR THIS TREATMENT?

WHAT ARE YOUR GOALS FOR YOUR HEALTH IN GENERAL?

ARE YOU CURRENTLY BEING TREATED FOR A MEDICAL CONDITION? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE:

WHAT CONDITION (S) OR ISSUE(S) WOULD YOU LIKE HELP WITH AT THIS OFFICE?:

PLEASE DESCRIBE ANY OTHER HEALTH CONCERNS:

ARE YOU CURRENTLY EXPERIENCING ANY ACUTE OR CHRONIC PAIN? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE THE LOCATION, QUALITY AND DURATION OF THE PAIN (S)

PLEASE LIST ANY SURGERIES OR HOSPITALIZATIONS (INCLUDE DATES):

PLEASE DESCRIBE YOUR EXERCISE ROUTINE:

PLEASE DESCRIBE ANY SIGNIFICANT TRAUMAS OR ACCIDENTS (PHYSICAL OR EMOTIONAL):

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? (PLEASE MARK BOTH PAST & PRESENT ONGOING USE)

☐ ANTACIDS	☐ ASPIRIN	☐ SEDATIVES	☐ ALLERGY
☐ LAXATIVES	☐ PAIN KILLERS	☐ INSULIN	☐ ANTIHISTAMINES
☐ APPETITE REDUCERS	☐ TYLENOL	☐ GLUCAGON	☐ ASTHMA MEDICATION
☐ FIBER SUPPLEMENTS	☐ ANTIDEPRESSANTS	☐ DIURETICS	☐ ANTIBIOTICS
☐ IBUPROFEN	☐ SLEEP AIDS	☐ THYROID REPLACEMENT	☐ BLOOD PRESSURE PILLS

PLEASE LIST ANY OTHERS MEDICATIONS:

DO YOU HAVE ANY DRUG OR FOOD ALLERGIES? ☐ YES ☐ NO IF YES, PLEASE LIST

PLEASE LIST ANY HERBS OR SUPPLEMENTS YOU ARE CURRENTLY TAKING (not already listed above):

PLEASE LIST THE FOODS THAT YOU AVOID OR TRY TO REDUCE AND WHY:

PLEASE DESCRIBE YOUR TYPICAL DAILY FOOD & DRINK INTAKE BELOW:

BREAKFAST	
LUNCH	
DINNER	
SNACKS	

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FAMILY HISTORY: (PLEASE MARK EACH BOX THAT APPLIES FOR A FAMILY MEMBER OR YOURSELF)

CONDITION	SELF	MOTHER	FATHER	SISTER	BROTHER	SPOUSE	CHILD
ALLERGIES	☐	☐	☐	☐	☐	☐	☐
BLOOD DISORDERS/ANEMIA	☐	☐	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐	☐	☐
ASTHMA	☐	☐	☐	☐	☐	☐	☐
THYROID DISORDER	☐	☐	☐	☐	☐	☐	☐
SEIZURES	☐	☐	☐	☐	☐	☐	☐
CANCER OR TUMORS	☐	☐	☐	☐	☐	☐	☐
CONDITION	SELF	MOTHER	FATHER	SISTER	BROTHER	SPOUSE	CHILD
SUBSTANCE ABUSE	☐	☐	☐	☐	☐	☐	☐
STOMACH OR INTESTINAL	☐	☐	☐	☐	☐	☐	☐
KIDNEY OR BLADDER	☐	☐	☐	☐	☐	☐	☐
HEPATITIS	☐	☐	☐	☐	☐	☐	☐
TUBERCULOSIS	☐	☐	☐	☐	☐	☐	☐
HIV	☐	☐	☐	☐	☐	☐	☐
DEPRESSION / ANXIETY	☐	☐	☐	☐	☐	☐	☐
OTHER							
AGE OF DEATH							

PERSONAL HABITS (PLEASE MARK ANY USE OF THE FOLLOWING NOW OR IN THE PAST)

		USE PER DAY/WEEK	AGE STARTED	AGE QUIT
ALCOHOL	☐ YES ☐ NO			
CIGARETTES	☐ YES ☐ NO			
MARIJUANA	☐ YES ☐ NO			
COCAINE	☐ YES ☐ NO			
HEROIN	☐ YES ☐ NO			
COFFEE / TEA	☐ YES ☐ NO			
OTHER:				

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HAVE YOU HAD ANY OF THE FOLLOWING SYPTOMS OR CONDITIONS?

(PLEASE CHECK ALL THAT APPLY)

General

Past Current

- ☐ ☐ Catch colds easily
- ☐ ☐ Night sweats
- ☐ ☐ Sweat easily
- ☐ ☐ Bleed or bruise easily
- ☐ ☐ Strong thirst
- ☐ ☐ No desire to drink
- ☐ ☐ Fatigue / low energy
- ☐ ☐ Sudden energy drops

Sleep

Past Current

- ☐ ☐ Difficult to fall asleep
- ☐ ☐ Wake easily during night
- ☐ ☐ Wake up too early
- ☐ ☐ Nightmares or vivid dreams
- ☐ ☐ Sleepwalking or talking
- ☐ ☐ Snoring
- ☐ ☐ Other:

Skin / Hair

Past Current

- ☐ ☐ Dry: skin / scalp / hair
- ☐ ☐ Rashes / hives / Eczema
- ☐ ☐ Itching
- ☐ ☐ Acne
- ☐ ☐ Change in moles
- ☐ ☐ Hair loss / thinning hair
- ☐ ☐ Other:

Head & Neck

Past Current

- ☐ ☐ Headaches / Migraines
- ☐ ☐ Dizziness / vertigo
- ☐ ☐ Facial paralysis or pain
- ☐ ☐ Concussions
- ☐ ☐ Other:

Nose/Throat

Past Current

- ☐ ☐ Nosebleeds
- ☐ ☐ Runny or stuffy nose
- ☐ ☐ TMJ or Grinding teeth
- ☐ ☐ Teeth / gum problems
- ☐ ☐ Recurrent sore throat
- ☐ ☐ Hoarseness / loss of voice
- ☐ ☐ Tonsillitis / swollen glands
- ☐ ☐ Sores on lips / mouth / gums
- ☐ ☐ Other:

Ears

Past Current

- ☐ ☐ Earaches

Eyes

Past Current

- ☐ ☐ Glasses / contacts
- ☐ ☐ Blurry vision
- ☐ ☐ Night blindness
- ☐ ☐ Sore or painful eyes
- ☐ ☐ Dry eyes
- ☐ ☐ Other:

Respiratory

Past Current

- ☐ ☐ Painful breathing
- ☐ ☐ Shortness of breath
- ☐ ☐ Excessive phlegm
- ☐ ☐ Chronic cough
- ☐ ☐ Coughing blood
- ☐ ☐ Asthma / wheezing
- ☐ ☐ Bronchitis
- ☐ ☐ Emphysema
- ☐ ☐ Pneumonia
- ☐ ☐ Other:

Cardiovascular

Past Current

- ☐ ☐ Pacemaker
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Chest discomfort / pain
- ☐ ☐ Heart palpitations
- ☐ ☐ Cold hands & / or feet
- ☐ ☐ Swelling of hands or feet
- ☐ ☐ Blood clots or Spider veins
- ☐ ☐ Fainting
- ☐ ☐ Other:

Genito-urinary

Past Current

- ☐ ☐ Painful urination
- ☐ ☐ Frequent or urgent urination
- ☐ ☐ Blood in urine
- ☐ ☐ Change in urinary flow
- ☐ ☐ Urinary incontinence
- ☐ ☐ Waking to urinate
- ☐ ☐ Recurrent bladder infections
- ☐ ☐ Recurrent yeast infections
- ☐ ☐ Kidney stones
- ☐ ☐ Prostate problems
- ☐ ☐ Change in sex drive
- ☐ ☐ Impotence
- ☐ ☐ Premature ejaculation
- ☐ ☐ Rashes / itching
- ☐ ☐ Other:

Digestive

Past Current

- ☐ ☐ Reduced or excess appetite
- ☐ ☐ Cravings for food or other
- ☐ ☐ Bad breath
- ☐ ☐ Belching
- ☐ ☐ Nausea or Vomiting
- ☐ ☐ Heartburn or indigestion
- ☐ ☐ Abdominal pain
- ☐ ☐ Weight gain or loss
- ☐ ☐ Loose stools / diarrhea
- ☐ ☐ Bloody stools
- ☐ ☐ Pale stools
- ☐ ☐ Black, tarry stools
- ☐ ☐ Constipation / dry stools
- ☐ ☐ Gas / bloating/ flatulence
- ☐ ☐ Gall bladder problems
- ☐ ☐ Appendicitis
- ☐ ☐ Hernia
- ☐ ☐ Rectal pain or Hemorrhoids
- ☐ ☐ Other:

Musculoskeletal

Past Current

- ☐ ☐ Neck pain / stiffness
- ☐ ☐ **Shoulder pain**
- ☐ ☐ Back pain
- ☐ ☐ Hand / wrist pain
- ☐ ☐ Knee pain
- ☐ ☐ Foot / ankle pain
- ☐ ☐ **Joint / bone problems**
- ☐ ☐ Muscle weakness
- ☐ ☐ Osteoporosis
- ☐ ☐ Herniated disc
- ☐ ☐ Sciatica
- ☐ ☐ Other:

Neurological

Past Current

- ☐ ☐ Seizures or Tremors
- ☐ ☐ Paralysis
- ☐ ☐ Stroke
- ☐ ☐ Nerve damage
- ☐ ☐ Numbness / tingling
- ☐ ☐ Lack of coordination
- ☐ ☐ Poor memory
- ☐ ☐ Other:

Infection Screening

Past Current

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Psychological / Behavioral

Past Current

- ☐ ☐ Depression
- ☐ ☐ Anxiety / nervousness
- ☐ ☐ Panic attacks
- ☐ ☐ Easily stressed
- ☐ ☐ Irritability
- ☐ ☐ Anorexia or Bulimia
- ☐ ☐ Overly emotional
- ☐ ☐ Treated for emotional issues?
- ☐ ☐ Other:

Gynecological

Past Current

- ☐ ☐ Irregular menses
- ☐ ☐ Painful menses
- ☐ ☐ Premenstrual symptoms
- ☐ ☐ Menopausal symptoms
- ☐ ☐ Abnormal PAP smear
- ☐ ☐ Abnormal bleeding
- ☐ ☐ Clots
- ☐ ☐ Fibroids

Gynecological (cont)

Past Current

- ☐ ☐ Painful intercourse
- ☐ ☐ Vaginal dryness
- ☐ ☐ Endometriosis
- ☐ ☐ Infertility
- ☐ ☐ Vaginal discharge
- ☐ ☐ Pain or itching of genitalia
- ☐ ☐ Vaginal sores
- ☐ ☐ Breast lumps
- ☐ ☐ Nipple discharge
- ☐ ☐ Other:

Are you now pregnant?

☐ yes ☐ no

Are you trying to become pregnant?

☐ yes ☐ no

Gynecological (cont)

Do you use birth control?

☐ yes ☐ no

If yes, what type & how long?

age of first menses:

# of pregnancies:

# of live births:

# of miscarriages:

# of Induced abortions:

Date of last Gyn exam:

Days between menses:

Duration of menses:

1st day of last menses:

Age at menopause:

ADDITIONAL COMMENTS: