

Infinite Wellness Acupuncture

401 23rd St #104 B Glenwood Springs, CO 81601 (970)-930-1809 Heather Douglas L.Ac

PATIENT INFORMATION & CONTACT INFO:

Name: _____

Date: _____

Address: _____

City, State & Zip: _____

Primary phone: _____

Work phone: _____

Is it okay to reach you at any of these phone numbers?

Yes No

Email: _____

Check here to opt out of email updates: _____

Age: _____ Birthdate: _____

Gender: _____ Pronoun: _____

Height: _____ Weight: _____

Filing status: Married or Single: _____

Yearly Household Income: _____

Occupation: _____

Company name: _____

Primary physician & phone number :

Another person we may contact if needed:

Name: _____

Relationship: _____

Phone: _____

How did you hear about us? _____

HEALTH HISTORY:

What are your primary health concerns for your treatment today?

1: _____

2: _____

How many hours do you average a night of sleep? _____

Any sleep complaints (wake often, hard to fall asleep, etc.)? _____

How many meals do you average a day? _____

How many snacks do you average a day? _____

Give a rough estimate of how much of your diet is *processed foods* (Added preservatives, additives, chemicals & fast food)? _____%

How much is *whole foods*? (One ingredient food items: Meats, Plant Starches, Grains, Good Fats, Fruits & Veggies)? _____%

Are there any food items or groups you avoid? _____

Any you limit? _____

How much water do you average a day? _____

How many bowel movements do you have a day? _____

Do you have an exercise regimen, if so explain: _____

Circle your stress level: mild, moderate or severe. Please list the top 3 stressors in your life: _____

Do you practice any type of relaxation practices, if so explain? _____

Do you drink caffeine, alcohol, use tobacco or any recreational drugs? If so, how much and often for each: _____

Are you currently taking any pain medications or blood thinners? (including aspirin) Yes No

List all medications, herbs or food supplements you are taking: _____

List serious illnesses, diagnosis, accidents, or surgeries _____

List any known allergies: _____

When was your last complete medical exam? _____

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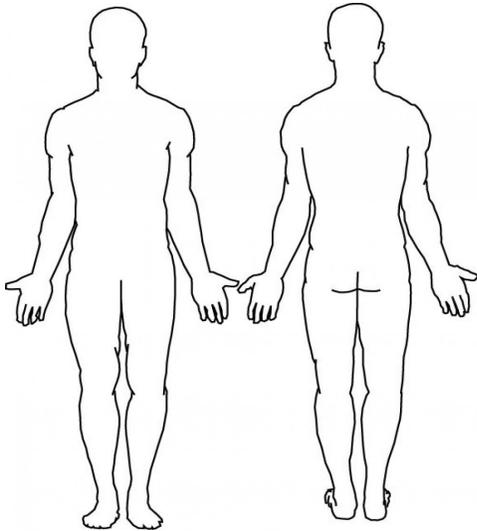
Checkmark symptoms you have had in the past & **Circle** symptoms you currently have:

- Anxiety Depression Difficulty focusing
- Addiction Dizziness Easily startled
- Excessive worry or fear Sigh often
- Excessive anger or irritability
- Overwhelmed by life Fatigue

- Headaches Migraines
- Loss or gain of weight Allergies Anemia
- Arthritis Bleeding disorder
- Cancer: type _____
- Diabetes Head Trauma
- Hepatitis (type _____) HIV/ AIDS
- Hypo/hyper thyroid Pacemaker
- Seizure Stroke

MUSCULOSKELETAL:

Any Discomfort? Circle what area of the body & describe the discomfort (type of pain, numbness, swelling, cramping, tremors, etc.)



EYES/EAR/NOSE/THROAT/RESPIRATORY:

- Asthma/wheezing Earache Eye pain
- Blurred or failing vision Difficulty breathing
- Hoarseness Enlarged glands Nosebleeds
- Frequent colds/flu Persistent cough
- Gum pain or bleeding Sinus problems
- Loss of hearing Ringing in ears

SKIN:

- Acne Boils Bruise easily
- Dry skin Itching/rash Sensitive skin
- Sore that won't heal Sweats

GASTROINTESTINAL:

- Belching Bloating Gas
- Colon issues Constipation Diarrhea
- Difficulty swallowing Gallbladder issues
- Excessive hunger Low Appetite
- Hemorrhoids Nausea
- Indigestion or pain Vomiting

CARDIOVASCULAR:

- Chest pain Hardening of arteries
- High blood pressure Low blood pressure
- Poor circulation Previous heart attack
- Rapid/irregular heart beat

URINARY:

- Bladder or urinary tract infection Bedwetting
- Blood/pus in urine Inability to control urine
- Frequent urination Kidney infection/stones

REPRODUCTIVE

MALE:

- Lowered libido Increased libido
- Erection difficulties Penis discharge
- Prostate issues Infertility

FEMALE:

- Lowered libido Increased libido
 - Abnormal vaginal discharge Infertility
 - Breast tenderness Breast lump
 - Bleeding in between periods Prolapse
 - PMS symptoms, explain: _____
 - Menstrual pain Clots in menses
 - Excessive menstrual flow Scanty flow
 - Irregular cycle Menopausal symptoms
 - Previous miscarriage (# _____)
 - Pregnancies to term (# _____)
- Could you be pregnant? _____

Please add any other symptoms/ concerns:

Circle all illnesses that have occurred to all blood relatives: Diabetes, High blood pressure, Stroke, Cancer, Heart disease, Kidney disease & other serious diagnoses?

This information is correct to the best of my knowledge.

PRINTED NAME:

PATIENT SIGNATURE:

(Or Patient Representative)