Infinite Wellness Acupuncture

1317 Grand Ave. #228 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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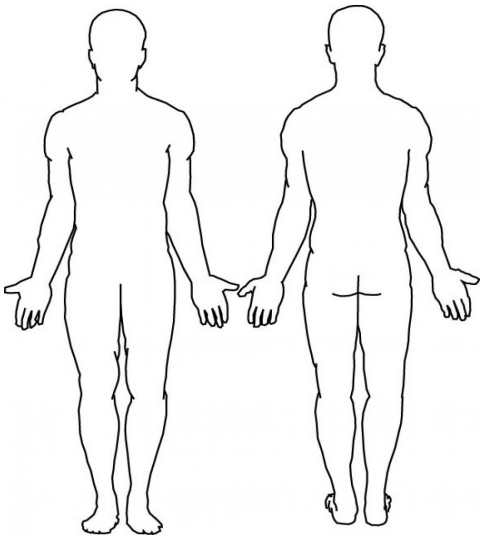
Checkmark symptoms *you have had in the past* & **Circle** symptoms *you currently have*:

□ 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/flus □ 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)