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# Welcome!

*Please take a few moments to help us understand how we can help you find greater balance and improved health.*

| | | |
|---|---|---|
| First Name: | Last Name: | Male/Female |
| Address: | | |
| City: | State: | Zip: |
| Home phone: | Cell phone: | |
| Email: | | |
| Date of birth: | Age: | Gender: |
| Emergency contact: | Relationship: | Tel. #: |
| Insurance Carrier: | | |
| Insurance Phone #: | Insurance ID#: | |
| Referred by: | | |

Please describe the main reason for your visit today.

_____
_____

If you have a medical diagnosis, please list here: _____

Please indicate if you have any of the following:

___ Cardiac pacemaker
___ Seizure disorder
___ Bleeding disorder
___ Fainting disorder
___ High blood pressure
___ Are/may be pregnant
___ HIV/AIDS positive
___ Hepatitis
___ Tuberculosis (TB)
___ Other _____

Please list all major childhood and adult illnesses.

_____
_____

Have you had any surgeries, major accidents or injuries? If so, please explain.

_____
_____

Family Medical History (please circle and indicate family member):

| | | |
|---|---|---|
| Stroke | Cancer | Asthma |
| Diabetes | High Blood Pressure | Other |
| Depression | Heart Disease | |

_____
_____

List all medications or supplements. Please include any herbs or vitamins you are currently taking:

_____
_____
_____

Please list your other healthcare professionals

| Name | Field of practice | Contact information |
|---|---|---|
| | | |
| | | |
| | | |

Occupation: _____

Do you have a regular exercise program? Please describe.

_____
_____

Do you follow a certain diet or way of eating? (vegetarian, gluten-free, paleo, restricted, medical etc)

_____
_____

Please describe your average daily diet:

| Morning | Afternoon | Evening |
|---|---|---|
| | | |
| | | |
| | | |

Do you smoke cigarettes? If so, how often? _____

Do you drink coffee, tea, or soft drinks? If so, which and how often? _____

Do you drink alcohol? If so, how often? _____

Please describe any use/frequency of recreational drugs for non-medical purposes.

_____

Do you have trouble falling asleep? Yes No

If yes, please explain. _____

Do you have trouble staying asleep? Yes No

If yes, please explain. _____

In which position do you most often sleep?
___ On Back ___ On Belly ___ On Side

What changes would you like to see in your life? _____

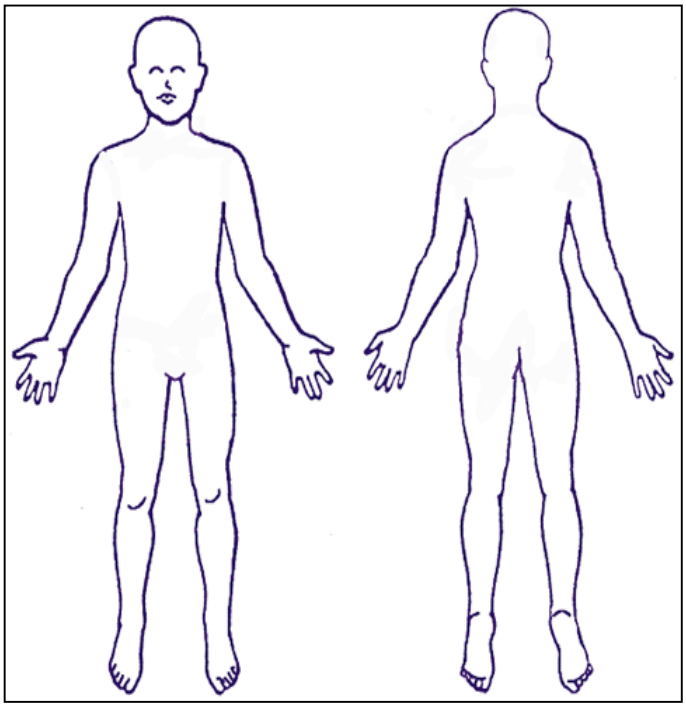
_____

_____

Have you received acupuncture before? _____ If so, for what reason? _____

_____

Please indicate all painful or distressed areas on figure.



**Women only:**

1. Are you pregnant now? Y N
2. Number of children _____
3. Number of pregnancies _____
4. Number of miscarriages _____
5. Number of abortions _____
6. Age of first period _____
7. Age of menopause if applicable _____
8. Last PAP _____
9. Are you taking birth control? If so, what kind?
   _____
10. Is your menses cycle regular Y N
11. a. Average # of days in flow _____
    b. The flow is
       ___ Normal
       ___ Heavy
       ___ Light
    c. The color is
       ___ Red
       ___ Dark
       ___ Purple
       ___ Light brown
       ___ Brown
    d. Do you have the following menses related symptoms?
       ___ Blood clots
       ___ Cramps
       ___ Nausea
       ___ Breast distension
       ___ PMS
       ___ Bleeding between periods
       ___ Heavy vaginal discharge between periods

**Men only:**

Do you experience any of the following?

___ Discharge
___ Pain or swelling of testicles
___ Ejaculatory problems
___ Impotence/erectile dysfunction

## PATIENT MEDICAL HISTORY

□ Cold hands/feet
□ Fatigue
□ Feverish in the afternoon or flushes
□ Heat sensation in hands, feet, chest
□ Night sweats
□ Catch colds easily
□ Sweats easily
□ Dizziness
□ See floating black spots
□ Itchy eyes
□ Blurry vision

_____

□ Palpitations
□ Sore on tip of tongue
□ Restlessness
□ Anxiety
□ Chest pain radiating to shoulder
□ Insomnia
□ High/low blood pressure
□ Fainting

_____

□ Cough
□ Sinus congestion/pressure
□ Nosebleeds
□ Dry mouth, throat, nose or skin
□ Allergies
□ Chills alternating with fever
□ Stiff neck/shoulders
□ Sore throat
□ Difficult breathing

_____

□ Low appetite
□ Loose stools
□ Constipation
□ Abdominal bloating or gas after eating
□ Feeling tired after eating
□ Prolapsed organs (previously diagnosed)
□ Bruises easily
□ General feeling of heaviness in body
□ Mental heaviness or fogginess
□ Swollen hands/feet
□ Burning sensation after eating
□ Bad breath
□ Weight gain
□ Post-nasal drip

□ Large appetite
□ Mouth/canker sores
□ Bleeding, swollen or painful gums
□ Heartburn/belching
□ Stomach pain
□ Vomiting/nausea
□ Weight loss

_____

□ General feeling of heaviness in body
□ Diarrhea alternating with constipation
□ Tight/suffocating feeling in chest
□ Bitter taste in mouth
□ Blood shoot eyes/dry eyes
□ Teeth/jaw clenching
□ Sighing
□ Anger easily
□ Skin rashes (psoriasis/eczema/acne etc)
□ Headache
□ Numbness of hands and feet
□ Muscle spasms, twitching, cramping
□ Seizures/convulsions
□ Depression
□ Ringing in ears

_____

□ Sore, cold or weak knees
□ Low back pain
□ Frequent urination
□ Get up more than once a night to urinate
□ Lack of bladder control
□ Memory problems
□ Hair loss
□ Ringing in ears

_____

Urine is:
□ Normal color □ Clear
□ Dark yellow □ Reddish
□ Cloudy □ Scanty
□ Bad odor
□ Burning □ Painful
□ Difficult □ Urgent

Libido (sex drive) is:
□ Normal □ Low □ High

_____ _____
**Please print your name** **Date**

_____
**Please sign your name**