

# Acupuncture & More

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## NEW PATIENT INFORMATION FORM

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

Name: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Email: \_\_\_\_\_ Work Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Single: \_\_\_ Married: \_\_\_ Divorced: \_\_\_ Widowed: \_\_\_ Partner: \_\_\_ Referred by: \_\_\_\_\_

Occupation: \_\_\_\_\_ Educational level: \_\_\_\_\_

Primary reason for visit today: \_\_\_\_\_

Additional concerns: \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Is this the first time? Yes \_\_\_ No \_\_\_

What seemed to be the initial cause? \_\_\_\_\_

What makes it better (heat, cold, rest, exercise, medications): \_\_\_\_\_

What seems to make it worse? \_\_\_\_\_

Does it interfere with your: Sleep \_\_\_ Work \_\_\_ Other Activities (what?) \_\_\_\_\_

### FAMILY HISTORY – Complete for each family member, indicating any past or present illness.

	Self	Mother	Father	Siblings	Children	Spouse
Cancer/Other Tumors	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Blood/bleeding disorders	_____	_____	_____	_____	_____	_____
Seizures	_____	_____	_____	_____	_____	_____
High/Low Blood Pressure	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
Allergies	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Drug Abuse	_____	_____	_____	_____	_____	_____
Depression	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Hepatitis	_____	_____	_____	_____	_____	_____
Kidney Disorders	_____	_____	_____	_____	_____	_____
Thyroid Disorders	_____	_____	_____	_____	_____	_____
Musculoskeletal Disorder	_____	_____	_____	_____	_____	_____
Blood Transfusion Before 1985	_____	_____	_____	_____	_____	_____
Age of Death	_____	_____	_____	_____	_____	_____

**PERSONAL LIFESTYLE HABITS**

Cigarettes (packs): \_\_\_\_\_ Coffee/Tea (cups): \_\_\_\_\_ Alcohol (drinks/week): \_\_\_\_\_

Marijuana: \_\_\_\_\_ Other recreational drugs: \_\_\_\_\_

Vitamins & herbs: \_\_\_\_\_

Dietary restrictions: \_\_\_\_\_

Food cravings: \_\_\_\_\_

**DIET** - What you might eat on a typical day?

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Type of Exercise: \_\_\_\_\_ How often: \_\_\_\_\_

What non-work activities do you enjoy doing? (Reading, TV, meditation, music, etc.): \_\_\_\_\_

\_\_\_\_\_

**MEDICINES**

Prescription drugs you are currently taking: \_\_\_\_\_

\_\_\_\_\_

For what condition(s): \_\_\_\_\_

\_\_\_\_\_

Current over-the-counter medication(s): \_\_\_\_\_

For what condition: \_\_\_\_\_

**MAJOR HOSPITALIZATIONS**

If you have ever been hospitalized for any serious medical illness or operation, write the most recent one below: (do not include normal pregnancies).

YEAR	OPERATION/ ILLNESS

Date of last physical examination: \_\_\_\_\_

Name of physician: \_\_\_\_\_

Physician address: \_\_\_\_\_

Physician phone: \_\_\_\_\_

Have you been treated with acupuncture or Chinese herbal medicine previously: yes \_\_\_ no \_\_\_

## **GYNECOLOGY**

Age of first menses: \_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_

Duration of flow: \_\_\_\_\_ Length of cycle: \_\_\_\_\_

Blood clots: yes \_\_\_ no \_\_\_ When: \_\_\_\_\_

Color of menstrual blood: pale \_\_\_ bright \_\_\_ red dark \_\_\_ red brown \_\_\_ other \_\_\_\_\_

Texture of menstrual blood: thick \_\_\_ thin \_\_\_ watery \_\_\_ normal \_\_\_

Pain: yes \_\_\_ no \_\_\_ When is the pain in your cycle: \_\_\_\_\_

Irregular periods (describe): \_\_\_\_\_

PMS (please describe): \_\_\_\_\_

Current method of contraception: \_\_\_\_\_ Past method(s): \_\_\_\_\_

Are you currently pregnant? yes \_\_\_ no \_\_\_ Number of pregnancies: \_\_\_\_\_

Number of live births: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Abortions: \_\_\_\_\_ Premature births: \_\_\_\_\_

Breast (lumps, cysts, tenderness, etc.): \_\_\_\_\_

Urinary tract infections: yes \_\_\_ no \_\_\_ Frequency: \_\_\_\_\_

Vaginal infections/ discharges (describe color): \_\_\_\_\_

Pain/itching of genitalia: yes \_\_\_ no \_\_\_ current \_\_\_ past \_\_\_

Pap smear: normal \_\_\_ abnormal \_\_\_ Date of last Pap smear: \_\_\_\_\_

Uterine fibroids: \_\_\_\_\_ Endometriosis: \_\_\_\_\_ Other: \_\_\_\_\_

Date of Onset of Menopause: \_\_\_\_\_ Any bleeding since: yes \_\_\_ no \_\_\_

Menopausal Symptoms: \_\_\_\_\_

Are you currently on Hormone Replacement Therapy (HRT)? yes \_\_\_ no \_\_\_ dose: \_\_\_\_\_

How long have you been on HRT: \_\_\_\_\_ Any side effects: \_\_\_\_\_

Please put a "**C**" if the condition is current or a "**P**" if you had it in the past

**General**

- Insomnia
- Dreams/ nightmares
- Irritability
- Depression
- Mood swings
- Fatigue
- Poor memory
- Strongly like cold drinks
- Strongly like hot drinks
- Recent weight loss/gain
- Cold hands & feet
- Chills
- Fever

**Head & Neck**

- Headaches
- Migraines
- Stiff neck
- Dizziness
- Fainting
- Swollen glands

**Ears**

- Ringing
- Hearing loss
- Infections
- Earache
- Hearing aids
- Vertigo

**Eyes**

- Glasses/ contact lenses
- Blurred vision
- Poor night vision
- Spots or floaters
- Eye inflammation
- Double vision
- Glaucoma
- Cataracts

**Nose, Throat & Mouth**

- Sinus infection
- Hay fever/ allergies
- Frequent sore throat
- Difficulty swallowing
- Mouth & tongue ulcers
- Frequent colds
- Nosebleed
- Dry nose
- Nasal congestion
- Loss of voice
- Thirst
- Excessive phlegm
- TMJ
- Facial pain
- Gum problems
- Dry mouth

**Skin**

- Hives
- Rashes
- Eczema/ psoriasis
- Night sweating
- Excess sweating
- Dry skin
- Easy bruising
- Changes in moles, lumps
- Itching

**Respiratory**

- Difficulty breathing
- Difficulty breathing when lying down
- Wheezing
- Asthma
- Chronic cough
- Wet cough
- Dry cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Tight chest
- Pneumonia

**Cardiovascular**

- High blood pressure
- Low blood pressure
- Chest pain or tightness
- Palpitation
- Rapid heart beat
- Irregular heart beat
- Poor circulation
- Swollen ankles
- Phlebitis
- Anemia
- History of heart attack

**Gastrointestinal**

- Nausea
- Indigestion
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Vomiting
- Gas
- Hiccups
- Acid regurgitation
- Bloating
- Bad breath
- Laxative use
- Bloody stool
- Mucus in stool
- Hemorrhoids
- Gall Bladder disorder

**Musculoskeletal**

- Joint pain/disorder
- Sore muscles
- Weak muscles
- Difficulty walking
- Neck/shoulder pain
- Upper back pain
- Lower back pain
- Rib pain
- Limited range of motion
- Other (describe)

**Neurological**

- Seizures
- Tremors
- Numbness or tingling
- Pain
- Paralysis
- Poor coordination
- Other (describe)

**Genitourinary**

- Pain on urination
- Frequent urination
- Urgent urination
- Blood in urine
- Unable to hold urine
- Incomplete urination
- Bedwetting
- Wake to urinate
- Increased libido
- Decreased libido
- Kidney stones
- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain/itching of genitalia
- Lumps in testicles

**Infection Screening**

- IV risks: self or partner
- TB: self or household
- Hepatitis risk: self or partner
- History of sexually transmitted disease: self or partner
- Gonorrhea
- Chlamydia
- Syphilis
- Genital warts
- Herpes: oral/ genital

**Other**

\_\_\_\_\_

\_\_\_\_\_

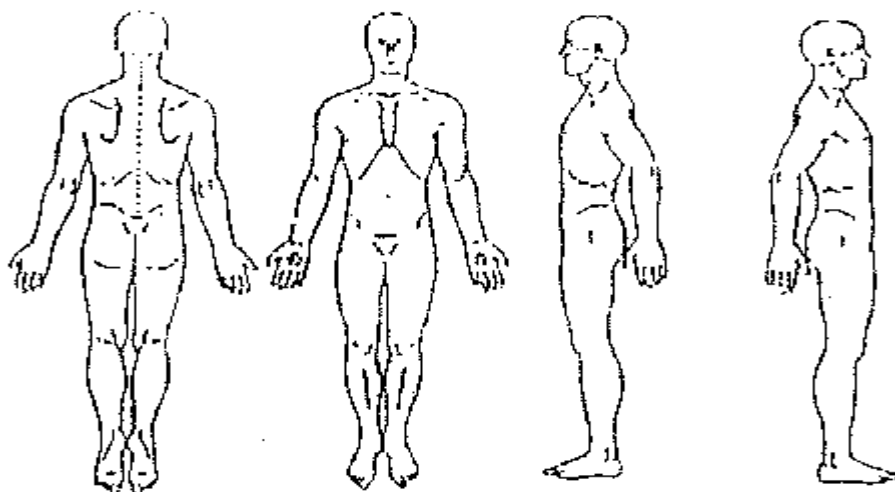
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\_\_\_\_\_

Please mark areas of pain:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1 2 3 4



SCAL 02

**CONSENT FOR TREATMENT:**

I, the undersigned, understand that acupuncture treatment involves the use of needles and may include acupressure, moxibustion, cupping, gua sha, and/or electrical stimulation. The risks, although limited, include puncturing organs in the abdomen and chest cavities, minor burns from moxibustion and bruising from gua sha or cupping techniques. Acupuncture may affect people on all levels including physical, mental, emotional and spiritual because it works with the whole body to create balance. The duration of the treatment varies from person to person depending on their specific illness and constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness of treatment after a specific treatment or series of treatments.

\_\_\_\_\_  
Patient's Signature (Parent or Guardian if Patient under age 18)

**Date:** \_\_\_\_\_