Acupuncture & More
Phone: 937/707-9953, 614/579-7550

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)

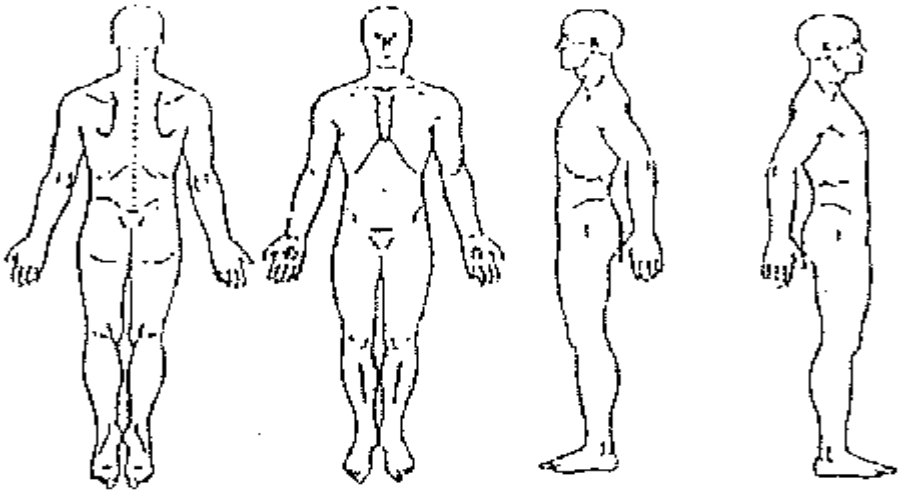
Neurological
___Seizures
___Tremors
___Numbness or tingling
___Pain
___Paralysis
___Poor coordination
___Other (describe)

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 _____
_____
_____
_____
_____

Please mark areas of pain:



SCALC 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.

_____ **Date:** _____

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