Acupuncture & More
Phone: 937/707-9953, 614/579-7550, 740/363-2179
Fax: 866/840-2170

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 ___

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)

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

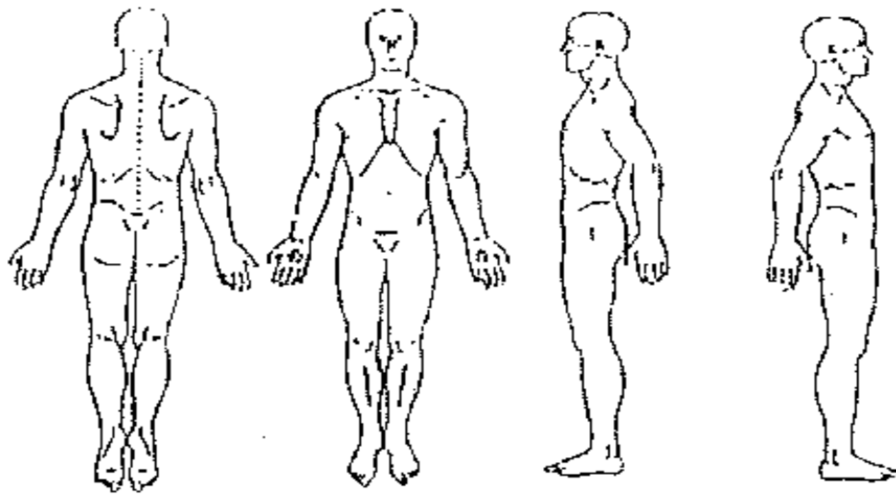
Musculoskeletal
___Joint pain/disorder
___Sore muscles
___Weak muscles
___Difficulty walking
___Neck/shoulder pain
___Upper back pain
___Lower back pain
___ Rib pain
___Limited range of motion
___Other (describe)

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

Please mark areas of pain:



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