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Date ____/_____/_____

Note: Information provided on this form is confidential

How did you hear about me? _____

Name _____Date of Birth ___/___/___ Age: _____

Pronoun Preference: _____

Address_____
_____

Email Address: _____

Phone Number: _____
Can we leave a message? _____

Emergency Contact Person_____
Relationship_____Tel:_____
Physician_____ Physician's phone # _____

Occupation_____

What do you want treated with acupuncture?
_____
_____
_____

Have you received a medical diagnosis for this condition and if so what is it? _____
_____
_____
What other treatments have you received for this condition? _____
_____
_____

What medications are you taking? REASON for taking?
_____
_____
_____
_____
_____
What vitamins or other supplements are you taking?
_____
_____
_____

Is this your first experience with acupuncture? _____
How do you feel about acupuncture? _____
_____

Are you currently pregnant?_____
Are you presently trying to get pregnant?_____

Past Medical History:
Have you had any of this condition(s)? Check all that apply:

□ AIDS/HIV	□ Herpes
□ Alcoholism	□ Joint Replacements
□ Allergies: If so what are they?	□ Lyme's Disease
□ Arthritis	□ Lymph Nodes removed
□ Asthma	□ Multiple Sclerosis
□ Autoimmune Disease: If so what are they?	□ Pacemaker
□ Birth Trauma	□ Seasonal Allergies
□ Cancer	□ Seizures
□ Diabetes	□ Sinus Infections
□ Drug Addictions	□ Tuberculosis
□ Emphysema	□ Operations: (for what?)
□ Fibromyalgia	
□ Heart Disease	
□ Hepatitis (Which one?)	□ Other:

Family Medical History: (Please list any significant family illnesses, e.g. diabetes, heart disease, respiratory conditions, blood pressure, neurological disorders, psychological disorders, arthritis, etc…..)
Mother: _____
Father: _____
Siblings: _____
Grandparents: _____

Exercise & Energy:
How is your energy? _____

What time of day is your energy the highest? _____Lowest? _____

Do you fatigue easily? _____

What kind of exercise do you do? _____

How often do you exercise? _____

Emotions & Sleep:
How do you feel emotionally? _____

_____

Do you have (circle for present/ underline for past): Panic attacks, Depression, Anxiety, Bad temper, Nervousness, Fear attacks, Poor memory, Difficult concentration

Are you in a relationship? Yes No
How do you feel about your relationship? _____

How do you hold stress? _____

How do you relax? _____

How do you feel about your work? _____

How long do you normally sleep? _____hours per night
I have difficulties with: Falling asleep, Staying asleep, Dream-disturbed sleep, Waking up at about _____am/pm and not being able to fall asleep again

Tobacco, Food and Drink Habits:

Do you smoke? No Yes _____per day, for _____years

Smoke previously? No Yes _____ ___per day, for _____years

Ever been treated for drug dependence? No Yes

Drink Alcohol? No Yes How much? _____

Drink Caffeinated Beverages? No Yes How much? _____

How many meals do you eat per day? _____
Go on diets often? No Yes

Any History of Psychological, Physical or Sexual Abuse that I should be aware of? No Yes

(Circle all that apply currently/ Underline all that applied in the past)

Gastrointestinal:
I have (circle for present/ underline for past): Belching, Nausea, Vomiting, Vomiting of blood Ulcers, Bloating, Acid regurgitation, Heartburn, Hernia, Indigestion, Severe stomach pain

Bowel movements: How often? _____time(s)/day _____days/week

I have (circle for present/ underline for past): Irregular, Constipation, Diarrhea, Gas, Burning sensation, Hemorrhoids, Undigested food in stool, Loose stool, Hard stool, Blood in stool, Itchiness, Painful bowel movements

Urinary: Uri**n**ation: How often? _____ (times per day)
Color: Pale yellow, Dark yellow/orange,
I have or had (circle for present/ underline for past): Trouble starting stream, Frequent urination, Incontinence, Pain, Burning, Dribbling when sneezing, Blood in urine, Kidney stones, Urinary tract infections

Other_____

Women:
At what age did you start menstruating? _____ Number of days between cycles: _____
Number of days of flow: _____ Color: _____

I have or had (circle for present/ underline for past): Irregular menstruation, Heavy flow, Light flow, No flow, Clots, Spotting between periods

Discomfort/pain before period, Discomfort/pain during period, PMS mood swings

Breast Lumps, Nipple Discharge, Breast Pain or Tenderness, Fibroids, Ovarian Cysts, Sexual Difficulties

Vaginal itching/burning, Vaginal discharge? No Yes Color_____

Menopausal Symptoms No Yes What: _____

Number of Pregnancies: _____ Number of Miscarriages: _____ Number of Abortions: _____

Men:
I have (circle for present/ underline for past): Prostate Disease, Impotence, Testicular Pain, Testicular Masses, Hernias
Other: _____

(Circle all that apply currently/ Underline all that applied in the past)

Muscles, Joints & Bones:
Do you have pain or tightness? No Yes

Where? _____

Please Describe Any Pain in Your Body: _____

_____

_____

The pain is: Sharp, Dull, Aching, Numb, Superficial Pain, Deep Pain, Burning, Tingling, Shooting, Pain worse/better with heat, Pain worse/better with cold, Pain worse/better with pressure, Pain worse in the morning, Pain worse in the evening

I have: Swollen joints, Arthritis/joint pain, Tendonitis, Bone pain, Muscle cramping, Muscle pain, Repetitive Strain Injury, Fractured Bone(s)

Where?_____

Other_____

Eyes, Ears, Nose, Throat, & Head:
I have (circle for present/ underline for past): Frequent colds, Chronic runny nose, Frequent sore throat, Chronic cough, Coughing blood, Cough up mucous, Pain inhaling, Shortness of breath on exertion/at rest, Asthma, Nose bleeds, Painful/red eyes, Poor vision, See spots/floaters, Dizziness, Cold sores, Bleeding gums, Dry mouth, Ear pain, Ringing in ears, Clogged/popping in ears

Frequent headaches/migraines- describe: _____

Cardiovascular:
I have (check for present/ underline for past): Chest pain, Palpitation, Varicose veins, Phlebitis, Cold hands and feet, Irregular heart beat, Poor circulation
Other:_____

Skin & Hair:
I have or often have (circle for present/ underline for past): Dry skin, Skin rashes, Itching, Acne, Eczema, Hives, Hair loss, Premature graying
Other:_____

Thank you for filling this form out completely!