HEALTHY LIVING ACUPUNCTURE AND WELLNESS

Patient Name _____ **Date** _____

General Information

Address _____ City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____ Referred By _____

Date of Birth _____ Occupation _____ ☐ Married ☐ Divorced ☐ Widowed ☐ Single

E-Mail _____ Receive email communications? ☐ Yes ☐ No

Emergency Contact _____ Relationship _____ Phone _____

Family Physician _____ Phone _____

Have you had Acupuncture or Oriental medicine before? ☐ Yes ☐ No

What was your experience? ☐ Very good ☐ Good ☐ No Change

Are you presently under a doctor's care? ☐ Yes ☐ No Who and what for? _____

Are there any other therapies that you are involved in? ☐ Yes ☐ No Who and what for? _____

Focus

What is the primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities?

☐ Work ☐ Sitting ☐ Relationships ☐ Recreation
☐ Sleep ☐ Standing ☐ Social Life ☐ Bending
☐ Walking ☐ Emotional ☐ Sexually ☐ Stretching
☐ Other: _____

What have you done about this? _____

What (functional) limitation, movement, and/or activity can you not do? _____

What are you health goals? _____

List any past or future surgeries: _____

List any significant trauma and when it occurred: _____

List exercise and sport activities you have been or are currently involved in: _____

Medical History

Do you have any allergies? ☐ Yes ☐ No If so, to what? _____

Do you take any medication? ☐ Yes ☐ No If so, what types and how often? _____

Do you take any pain medication? ☐ Yes ☐ No If so, what types and how often? _____

Do you take supplements? ☐ Yes ☐ No If so, what types and how often? _____

Please indicate if you or any family members have or had any of the following conditions:

☐ Pneumonia	☐ Drug reaction	☐ Mental breakdown	☐ Gonorrhea/Herpes	☐ Mental illness
☐ Tuberculosis	☐ Heart attack	☐ Jaundice	☐ HIV/AIDS	☐ Hypo/Hyper thyroid
☐ Hepatitis	☐ Blood transfusion	☐ Parasites	☐ Cancer	☐ Premature graying
☐ Diabetes	☐ Anemia	☐ Measles	☐ Heart disease	☐ Seizures
☐ Epilepsy	☐ Arthritis	☐ Mumps	☐ Gout	☐ Multiple Sclerosis
☐ Kidney Stone	☐ Obesity	☐ Syphilis	☐ High/Low blood pressure	

Do you sleep well? ☐ Yes ☐ No Do you dream? ☐ Yes ☐ No

Do you have a high point during the day? ☐ Yes ☐ No When? _____

Do you have a low point during the day? ☐ Yes ☐ No When? _____

Female / Male Concerns

Date of last menstruation _____ Is your cycle regular? ☐ Yes ☐ No Is your cycle painful? ☐ Yes ☐ No

Have you been pregnant? ☐ Yes ☐ No Birth control? ☐ Yes ☐ No How long? _____

☐ PMS ☐ Clotting ☐ Vaginal sores ☐ Vaginal pain ☐ Other _____

☐ Testicle pain ☐ Penis pain ☐ Penis Sores ☐ Discharge ☐ Premature ejaculation ☐ Nocturnal emission

☐ Impotence ☐ Other _____

Signs / Symptoms

☐ Abdominal pain/distention	☐ Cough	☐ Headache	☐ Mouth sores	☐ Seizures
☐ Abuse survivor	☐ Cough Blood	☐ Hemorrhoids	☐ Mucus in stools	☐ Short temper
☐ Acid regurgitation	☐ Decreased libido	☐ Heart palpitations	☐ Muscle cramps/pain	☐ Shortness of breath
☐ Acne	☐ Depression	☐ Hiccup	☐ Nasal congestion	☐ Sinus pressure
☐ Asthma	☐ Dizziness/Vertigo	☐ High Blood Pressure	☐ Neck/shoulder pain	☐ Skin fungal infection
☐ Bad breath	☐ Dry throat/mouth	☐ Increased libido	☐ Night sweat	☐ Spots in eyes
☐ Blood in stool	☐ Diarrhea	☐ Indigestion	☐ Nose bleeds	☐ Sweat easily
☐ Blood in urine	☐ Earaches	☐ Intestinal pain/cramps	☐ Numbness	☐ Sore throat
☐ Blurry vision	☐ Enlarged thyroid	☐ Irritable	☐ Odorous stools	☐ Sudden energy drop
☐ Bowel Movements	☐ Eye pain/strain	☐ Itchy eyes	☐ Pain upon urination	☐ Swollen glands
Frequency_____	☐ Excessive phlegm	☐ Itchy skin	☐ Peculiar tastes	☐ Teeth/gum problems
☐ Breast lump/pain	Color_____	☐ Joint pain	☐ Poor appetite	☐ Ulcerations
☐ Bruise easily	☐ Excessive saliva	☐ Kidney stones	☐ Poor circulation	☐ Upper back pain
☐ Chest pains	☐ Fatigue	☐ Laxative use	☐ Poor memory	☐ Urgent urination
☐ Chills	☐ Fever	☐ Limited range motion	☐ Poor sleep	☐ Vomiting
☐ Cold hands/feet	☐ Frequent urination	☐ Loss of hair	☐ Psoriasis	☐ Wake to urinate
☐ Concussion	☐ Gas/Belching	☐ Low back pain	☐ Rash	☐ Weight loss/gain
	☐ Grinding teeth	☐ Migraine	☐ Redness of eyes	☐ Wheezing

Other: _____

Pain

Use the diagram and pain key to the right to indicate areas and type of pain.
Use the chart below to indicate pain intensity and limitations.

Pain intensity levels

☐ No Pain ☐ Moderate pain ☐ Severe pain ☐ Terrible pain

Sleeping

☐ No problem ☐ Disturbed ☐ Very disturbed ☐ Cannot sleep

Work – Can do:

☐ Usual work ☐ 50% of work ☐ 25% of work ☐ Cannot work

Frequency of pain

☐ 25% of time ☐ 50% of time ☐ 75% of time ☐ 100% of time

Travel

☐ No problem ☐ Moderate pain on trips ☐ Severe pain

Recreation – Can do:

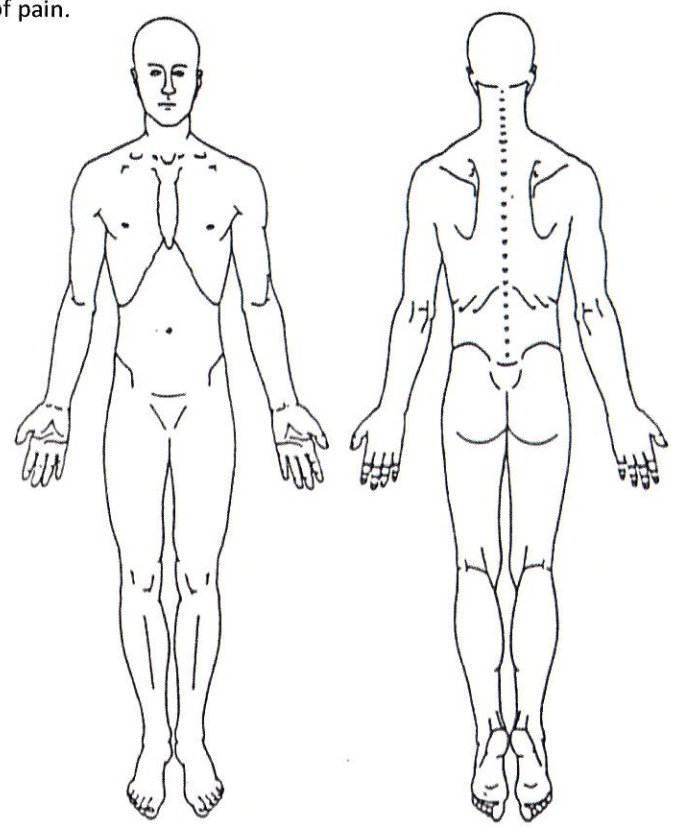
☐ All activities ☐ Some activities ☐ No activities

Walking

☐ Can walk fine ☐ Pain after ½ mile ☐ Cannot walk

Sitting

☐ No pain sitting ☐ Some pain while sitting ☐ Cannot sit



Pain Key

Ache	Numbness	Pins & Needles	Burning	Stabbing
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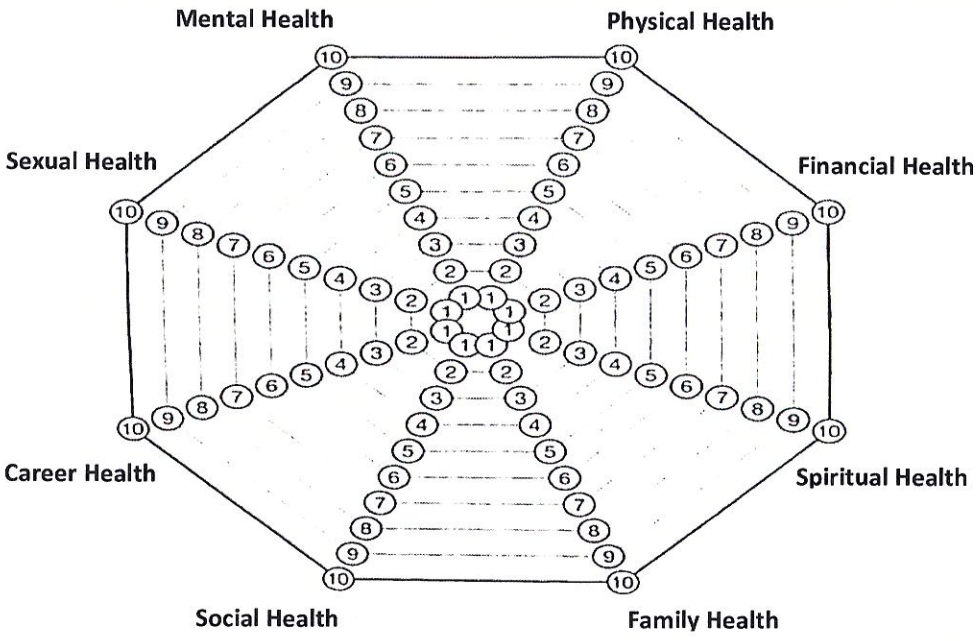
Web of Wellness

Health and wellness are a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well-being.

Using the diagram to the right, choose your level of satisfaction in each of the areas. For example, If you are extremely satisfied with your career, shade in the "10" circle on the career health line.

1 = Extremely unsatisfied
5 = Neutral
10 = Extremely satisfied



Commitment

On a scale from 1-10, how committed are you to correcting your problem(s)?

not committed 1 2 3 4 5 6 7 8 9 10 very committed