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Patient Information

All information is confidential and is used to determine the best treatment plan for you. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition.

Date _____

Name _____

Address _____

City/State/Zip _____

Home Phone _____ Cell Phone _____

Email _____

Emergency Contact name/number/relationship _____

May these numbers/email be used to contact you regarding appointments/discussion of treatments?

yes ___ no ___ *Can messages be left at these numbers? yes ___ no ___*

Date of Birth _____ Age _____ Marital Status _____

Gender _____ Height _____ Weight _____

Have you had acupuncture before? _____

Are you currently under the care of a physician? _____ If so, who _____

For what condition(s)? _____

Main reason(s) for seeking acupuncture _____

How long have you experienced symptoms? _____

Your condition is improved by _____

Your condition is aggravated by _____

List any prescriptions, over-the counter medications, supplements or vitamins you are taking

<i>name</i>	<i>dosage/frequency</i>	<i>reason</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Indicate if any of the following pertain to you (*marking yes does not make you ineligible for treatment, however, it may restrict some of the treatment modalities*)

Hepatitis ___ HIV/AIDS ___ Hypertension ___ Seizures ___
Pacemaker ___ Migraines ___ Pregnancy ___ Blood Thinning Medication ___

Describe significant illnesses that apply to you or a blood relative with approximate dates

Cancer _____ Diabetes _____
Depression _____ Stroke _____
Emotional Disorders _____ Seizure _____
Heart Disease _____ Tuberculosis _____
Hepatitis _____ Infectious Disease _____
Hypertension _____ Shingles _____
Any additional health issues _____

List any accidents, surgeries or hospitalizations with approximate dates

List any allergies or food sensitivities

Describe your typical diet

breakfast _____
lunch _____
dinner _____
snacks _____
how many meals per day _____ how may snacks per day _____

Describe use and frequency

caffeinated drinks _____
water intake _____
alcohol intake _____
soda _____
tobacco _____
recreational drugs _____

Do you exercise _____ If so, describe what you do and how often _____

How do you feel about the following areas of your life

	<i>great</i>	<i>good</i>	<i>fair</i>	<i>poor</i>	<i>bad</i>
significant other	_____	_____	_____	_____	_____
family relations	_____	_____	_____	_____	_____
self image	_____	_____	_____	_____	_____
sex	_____	_____	_____	_____	_____
work	_____	_____	_____	_____	_____
exercise	_____	_____	_____	_____	_____
spirituality	_____	_____	_____	_____	_____

Age menses began _____ Are you still menstruating yes ___ no ___

Date of last period _____ Are you pregnant now yes ___ no ___

Date of your last ob/gyn exam _____

- | | | |
|-------------------|------------------------|------------------------------------|
| ___ live births | ___ fibroids | ___ STD |
| ___ miscarriage | ___ endometriosis | ___ human papilloma virus |
| ___ termination | ___ vaginal discharge | ___ herpes |
| ___ infertility | ___ vaginal odor | ___ birth control, type used _____ |
| ___ breast cancer | ___ fibrocystic breast | |
| ___ ovarian cysts | ___ uterine prolapse | |

Number of days between periods _____ How many days do you bleed _____

<i>Color of blood</i>	<i>Amount of blood</i>	<i>How many pads/tampons used</i>
___ pale/light red	___ spotting	day 1 _____
___ red	___ light	day 2 _____
___ bright red	___ even throughout	day 3 _____
___ dark red	___ heavy	day 4 _____
___ dark red/brown		day 5 _____
___ clots		+ days _____

Are your periods painful:

- | | | | | |
|---------|-------------------|-------------------|-----------------|--------------|
| ___ yes | ___ before period | ___ mild pain | ___ low abdomen | ___ cramping |
| ___ no | ___ during period | ___ moderate pain | ___ low back | ___ stabbing |
| | ___ after period | ___ severe pain | ___ thighs | ___ aching |
| | | | ___ other | ___ burning |
| | | | | ___ dull |
| | | | | ___ constant |
| | | | | ___ come/go |

Other symptoms related to period (check all that apply)

- | | |
|------------------|------------------------|
| ___ discharge | ___ swollen breasts |
| ___ PMS | ___ mood swings |
| ___ headache | ___ increased appetite |
| ___ nausea | ___ decreased appetite |
| ___ constipation | ___ insomnia |
| ___ diarrhea | |

SYMPTOMS Check symptoms you currently have or have had in the past year.

HEAD & NECK

- dizziness
- fainting
- headaches
- foggy headed
- other

EYE, EAR, NOSE & THROAT

- blurred vision
- dry eyes
- spots/floaters
- hearing loss
- ringing in ears
- nosebleeds
- sinus congestion
- decreased sense of smell
- dry nose/throat
- difficulty swallowing
- mouth ulcers
- bitter/metallic taste in mouth
- other

RESPIRATORY

- persistent cough
- asthma
- allergies
- frequent colds
- shortness of breath
- other

SKIN

- bruise easily
- hives
- itching
- rashes
- eczema/psoriasis
- dryness
- excess sweating
- spontaneous sweating
- night sweats
- change in moles
- hair loss
- other

CARDIOVASCULAR

- palpitations
- chest pain or tightness
- rapid heart beat
- high blood pressure
- low blood pressure
- irregular heart beat
- poor circulation
- swelling of ankles
- varicose veins
- other

GASTROINTESTINAL

- poor/excessive appetite/thirst
- nausea
- bloating
- stomach pain
- vomiting
- reflux/heartburn
- fatigue after meals
- difficulty digesting oily foods
- constipation
- diarrhea/loose stool
- hemorrhoids
- other

GENITOURINARY

- cloudy urine
- frequent urination
- lack of bladder control
- painful urination
- blood in urine
- other

NEUROLOGY

- seizures
- tremors
- pain
- paralysis
- numbness/tingling

MUSCLE, JOINT, & BONE

- joint disorder
- difficulty walking
- spinal curvature
- muscle spasms or twitching
- sore, cold, weak knees
- back pain
- neck/shoulder tension
- other

pain, numbness or weakness in:

- arm
- neck
- shoulder
- back
- hips
- legs
- feet
- other

GENERAL

- insomnia
- anxiety
- sadness
- mentally restless
- irritability
- feelings of claustrophobia
- obsession in work, relations...
- difficulty in making decisions
- vivid dreams or nightmares
- decreased sex drive
- cold hands/feet
- hot hands/feet
- body feels heavy
- afternoon fevers