

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 many 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	_____	_____	_____	_____	_____

Date of last prostate check-up _____

PSA results _____ Lab results/diagnosis _____

Frequency of urination: daytime _____ night time _____

Color of urine: clear ___ murky ___ Any odor _____

Additional Symptoms (check all that apply): prostate problems ___ rectal dysfunction ___

back pain ___ delayed stream ___ increased libido ___ decreased libido ___ groin pain ___ dribbling ___

testicular pain ___ incontinence ___ premature ejaculation ___ retention of urine ___ impotence ___

other symptoms:

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