Patient Information

Name: _____ Today's date_____
Address:_____
Phone:_____Email:_____
Birthdate: _____ Age: _____
Gender: _____ Height: _____ Weight: _____
Current relationship status: _____
Occupation: _____ Employer: _____
Emergency contact:_____ Emergency contact phone:_____

How did you hear about our clinic? _____
Have you experienced acupuncture before? _____
If yes, what conditions treated? _____

Primary physician: _____ Phone: _____
OB/GYN: _____ Phone: _____
Other specialist: _____Phone: _____

Health History

Name: _____ Today's date: _____
Reason for visit: please list your 5 major health concerns in order of importance:
1._____
2. _____
3. _____
4. _____
5. _____

Are you seeing another health care practitioner for these concerns?
_____
What is your goal or hope in seeking treatment with me?
_____

Major surgeries, injuries, hospitalizations:

Year	Type	Outcome

Medications, supplements and herbs: please list what you are taking:

Item	Amount	Frequency	Start date

Please list any allergies or sensitivities you are aware of:

_____

_____

Diet and lifestyle

Typical daily diet:

Breakfast: _____

Lunch:_____

Dinner: _____

Snacks: _____Fluid intake: _____

Do you have a special diet now or have you had one in the past? _____

	Yes	No	Amount per day/week	Age started	Age quit
Coffee/Tea					
Soda					
Alcohol					
Cigarettes					
Marijuana					

Temperature

Please check all that apply:

Cold hands		Hot hands		Thirst	
Cold feet		Hot feet		Absence of thirst	
Numbness		Heat in chest		No desire to drink	
Night sweats		Hot in afternoon		Excessive thirst	
Unusual sweating		Hot/hot flashes at night			

Sleep

of hours per night:_____ Typical hours of sleep: _____ am/pm to _____ am/pm

Do you wake nightly? _____ How many times per night?_____ At what time usually? _____ am/pm

Do you wake to urinate? _____ How many times?_____

Difficulty falling asleep ___ Restless sleep ___ Wake early ___ Disturbing dreams ___ Wake unrested___

Urinary

Decrease in flow		Dribbling/Incontinence		Pain	
Difficulty start/stop		Frequent urination		Burning	
Urgency		Cloudy Urine		Cloudy Urine	

Moisture

Dry skin		Dry mouth, lips or throat		Oily skin/hair	
Dry eyes		Dry nose		Itching	
Dry brittle nails		Nosebleeds		Pimples/acne	
Edema/swelling		Rashes		Dandruff	

Energy

Weight gain		Sudden energy drop?		Headaches	
Weight loss		Energy drop after eating		Location of headache	
Body/limbs feel weak		Fatigue		Difficulty concentrating	
Body/limbs feel heavy		Wired/ungrounded		Dizziness/lightheaded	
Bleed/bruise easily		Stimulant dependence		Poor memory	
Blood pressure high/low		Shortness of breath		Heart palpitations	

Digestion

Bowel movements: How often?_____ per _____

Stools keep shape? ___ yes ____ no

Diarrhea		Tired after BM		Poor appetite	
Dry stools		Foul smelling BM		Indigestion	
Constipation		Bad breath		Bloating	
Pain with BM		Excessive appetite		Gas	
Difficult to pass		Vomiting		Nausea	
Hemorroids		Hernia		Heartburn	

EENT

Poor vision		Sinus congestion		Dental problems	
Night blindness		Excessive earwax		Mouth sores	
Spots in vision		Poor hearing		Sore throat	
Red eyes		Ringing in ears		Cough/phlegm	

Emotions

Do you experience mood swings?

Which emotions resonate with you?

Anger		Anxiety		Timidity/Shyness	
Irritability		Worry		Indecisiveness	
Grief		Obsessive thoughts		Joy	
Sadness		Depression		Fear	

Female Focus

Age at first menses: _____
Average length of full cycle: _____days (# of days from 1st day of period to the 1st day of the following period)
Average length of menstrual flow: _____days
Last menses start date: _____ Have your menses changed since puberty?_____
# of pregnancies: _____ # of children: _____ Home or hospital birth? _____
Miscarriage(s)? _____ If yes, when? _____ Abortion(s)?_____ If yes, when? _____
D&C?_____ If yes, when? _____
What types of contraception do you or have you used? How long did you use each?
_____
Are you currently sexually active? _____

Flow: _____Heavy _____Medium _____Light _____Spotting
Color: _____Pale _____Medium Red _____Dark Red _____Brown _____Purple
Menstrual Pain: _____Mild _____Moderate _____Severe
___Before bleeding ___First day ___During period ___More than 2 days
What is the quality of the pain?_____ Pain medication? What type?_____
Clots: ___Small ___Large ___Few ___Many
Do you experience premenstrual symptoms?___Acne ___Breast tenderness ___Irritability ___Other_____
Discharge/cervical fluid?_____Thin or thick?_____ Color?_____ Odor?_____

Abdominal bloating		Breast pain		Hair loss	
Water retention		Fibrocystic breasts		Excessive facial hair	
Abdominal pain		Fibroids		Excessive body hair	
Low back pain		Polyps		Anemia	
Pelvic pain		PCOS		Endometriosis	
Pelvic inflammatory disease		HRT		Urinary tract infections	
Perimenopause		Pain at ovulation		Yeast infections	
Vaginal dryness		Genital discharge		Thyroid issues	

Fertility

How long have you been trying to get pregnant? _____
Are you presently seeing a Fertility Doctor?_____
If so, name of Fertility Doctor and clinic _____
Have you had a diagnosis relating to fertility? _____
Have you had fertility treatments? If so, what treatment and when?
_____
Have you taken medication to increase ovulation? If so, when and how long?
_____
Have your fallopian tubes been medically evaluated? If so, what were the results?
_____
Have you had any hormone laboratory tests? If so, when and what were the results?
_____
Has your partner had a fertility work-up? If so, what were the results?
_____
How often do you have intercourse? _____