ACUPUNCTURE ASSOCIATES
Traditional Chinese Medicine

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www.happyacupuncture.com

Confidential Patient Information Sheet

Patient Information

Name _____ SSN _____ Date _____

Address _____ City _____ State _____

Zip _____ Home phone _____Work phone _____ Cell _____

Email _____ Have you had acupuncture before? ☐ Yes ☐ No

Height _____ Weight _____ Age _____ Sex: ☐ Male ☐ Female Date of birth _____

Occupation _____ Employer _____

Annual Income Range: ☐ Less than $49,000 ☐ $50,000 to $99,000 ☐ $100,000 to $249,000 ☐ $250,000 + ☐ Retired

In emergency notify (name): _____ Emergency phone number: _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed ☐ Separated

Number of children: _____ Ages of children: _____ Number who live with you: _____

Others living with you: _____

Primary Care Doctor: _____ Last seen: _____

How did you hear about Acupuncture Associates: ☐ Yellow Pages ☐ Article ☐ A Talk ☐ Brochure
☐ Business Card ☐ Web site ☐ Newspaper ☐ Referred by: _____

Medical History

Reason for your visit here today: _____

Are you being treated for this condition by anyone else: ☐ Yes ☐ No

If Yes, who? _____ Phone number: _____

Has this condition been diagnosed by a MD? ☐ Yes (Diagnosis: _____) ☐ No

Have these treatments helped? ☐ Yes ☐ Somewhat ☐ Not much ☐ Not at all

How does this condition affect you? _____

How long have you had this condition? _____

Do you currently have any infectious disease? ☐ Yes ☐ No ☐ Possibly

If Yes, please identify: ☐ HIV+ ☐ Hepatitis B ☐ Hepatitis C ☐ Flu / Cold ☐ Streptococcus
☐ Mononucleosis ☐ Tuberculosis ☐ Other: _____

Known or suspected allergies: _____

Childhood diseases you have had: ☐ Chicken Pox ☐ Measles ☐ Mumps ☐ Rheumatic Fever ☐ Diphtheria
☐ Scarlet Fever ☐ Other _____

Physical or Emotional Traumas / Accidents / Hospitalizations / Surgeries in the past 10 years:

Reason Date / Year(s)

_____

_____

_____

Health Inventory

Cardiovascular Conditions:

- ☐ Heart Disease
- ☐ A Pacemaker
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Edema

Emotional / Mental:

- ☐ Clinical Depression
- ☐ Mild Depression
- ☐ ADD or ADHD
- ☐ Schizophrenia
- ☐ Mood Swings
- ☐ Panic Attacks
- ☐ Nervousness
- ☐ Anxiety
- ☐ Alzheimer's
- ☐ Dementia

Energy & Immunity:

- ☐ Chronic Fatigue Syndrome
- ☐ General Fatigue
- ☐ Slow Wound Healing
- ☐ Easy Bruising
- ☐ Chronic Infections
- ☐ Frequent Allergies

Respiratory:

- ☐ Pneumonia
- ☐ Asthma
- ☐ Frequent Common Colds
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Persistent Cough
- ☐ Pleurisy
- ☐ Tuberculosis
- ☐ Shortness of Breath

Musculo-Skeletal:

- ☐ Neck / Shoulder Pain
- ☐ Muscle Spasms / Cramps
- ☐ Arm Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Leg Pain
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Joint Pain

Head, Eye, Ear, Nose & Throat:

- ☐ Impaired Vision
- ☐ Eye Pain / Strain
- ☐ Glaucoma
- ☐ Glasses / Contacts
- ☐ Tearing / Dryness
- ☐ Impaired Hearing
- ☐ Ear Ringing
- ☐ Earaches
- ☐ Ear Infections
- ☐ Headaches
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Teeth Grinding
- ☐ Frequent Sore Throats
- ☐ TMJ / Jaw Problems
- ☐ Hay Fever

Genito-Urinary Tract:

- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Painful Urination
- ☐ Dribbling Urination
- ☐ Frequent UTI
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Discharge
- ☐ Incontinence

Neurological

- ☐ Vertigo / Dizziness
- ☐ Paralysis
- ☐ Numbness / Tingling
- ☐ Loss of Balance
- ☐ Seizures / Epilepsy
- ☐ Dyslexia

Gastrointestinal:

- ☐ Stomach Ulcers
- ☐ Changes in Appetite
- ☐ Nausea / Vomiting
- ☐ Epigastric / Abdominal Pain
- ☐ Passing Gas
- ☐ Heart Burn
- ☐ Belching
- ☐ Gall Bladder Disease
- ☐ Gall Bladder Stones
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Diarrhea

Endocrine:

- ☐ Hypothyroid
- ☐ Hypoglycemia
- ☐ Hyperthyroid
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Night Sweats
- ☐ Unusual Sweating
- ☐ Feeling Hot or Cold

Other:

- ☐ Cancer
  Type: _____
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Candida
- ☐ Anemia
- ☐ Rashes
- ☐ Eczema / Hives
- ☐ Cold Hand / Feet
- ☐ Hemophilia
- ☐ Thin / Graying hair

Liver Conditions:

- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

Men Only:

- ☐ Impotence
- ☐ Vasectomy
  Date: _____
- ☐ Prostate Problems
- ☐ Testicular Pain / Redness / Swelling
- ☐ Low libido
- ☐ Excessive libido
- ☐ Painful Intercourse
- ☐ Seminal emissions

Women Only:

Are you pregnant right now? ☐ Yes ☐ No ☐ Trying ☐ Maybe Method of Birth Control: _____

Age at first period: _____ Date of last menses: _____ Age at menopause: _____

Typical length of menses (days): _____ Typical length of cycle (from 1st day to 1st day of menses): _____

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

Hysterectomy: ☐ Yes ☐ No Date: _____

Check all that apply: ☐ Low libido ☐ Excessive libido ☐ Painful Intercourse ☐ Clotting ☐ Painful Periods ☐ Heavy Flow ☐ Scanty Flow ☐ Bleeding Between Cycles ☐ Irregular Cycles ☐ Vaginal Discharge ☐ Breast Lumps / Tenderness ☐ Nipple Discharge ☐ Infertility ☐ Menopausal Symptoms ☐ Premenstrual Problems

Medications

Please list all prescription and over the counter medications you are currently taking:

Drug Name	Reason for taking	For how long	Dose	Frequency

Please list all supplements and herbs you are currently taking:

Supplement	Reason for taking	Potency	Frequency

Lifestyle

(Daily amount used within the past 2 months)

Tobacco: ☐ Yes ☐ No Amount: _____ Alcohol: ☐ Yes ☐ No Amount: _____

Coffee: ☐ Yes ☐ No Amount: _____ Recreational Drugs: ☐ Yes ☐ No Amount: _____

Do you feel at or near your ideal weight? ☐ Yes ☐ No

Do you feel you have enough energy? ☐ Yes ☐ No Are you vegetarian or vegan? ☐ Yes ☐ No

Best time of day: _____ Worst time of day: _____

Favorite Season: _____ Hours of sleep / night: _____

Do you feel rested after a nights sleep? _____ Do you remember your dreams? _____

Typical day's meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks / Other: _____

Food cravings: _____

Religion or other spiritual practice: _____

Hobbies or other recreation: _____

What kind of physical exercise you do regularly? _____

Hours of television watched per week? _____ Hours of work per week? _____

Highest level of education completed? ☐ High School ☐ Bachelors ☐ Masters ☐ Doctorate ☐ Other

How would you rate your current stress level? ☐ Extreme ☐ Very High ☐ High ☐ Moderate ☐ Low

Emotions / Relationship

Number of biological Brothers: _____ Sisters: _____ Were you adopted? ☐ Yes ☐ No

Your place in the birth sequence#: _____

Did you feel safe and nurtured as a child? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

What would you characterize as your predominate emotion right now? ☐ Anxiety / Worry ☐ Anger ☐ Grief ☐ Fear / Dread ☐ Depression ☐ Melancholy ☐ Happiness ☐ Contentment ☐ Joy ☐ Numbness / Apathy ☐ Other: _____

Do you enjoy your work? ☐ Yes ☐ Usually ☐ Sometimes ☐ Rarely ☐ No

Why or why not? _____

Do you feel you have a higher purpose for your life? ☐ Yes ☐ Usually ☐ Sometimes ☐ Rarely ☐ No

Do you feel safe in your current significant relationship(s)? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

Do you feel nurtured in your current significant relationship(s)? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

Are you happy with your current significant relationship(s)? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

Are you satisfied with your sex life? ☐ Yes ☐ Usually ☐ Sometimes ☐ Rarely ☐ No

If you were guaranteed of success and money and time were not obstacles, what would you like to do with your life? _____

_____

Please feel free to express any concerns or thoughts you feel may be relevant to your health below: Use the diagram if desired.

_____
_____
_____
_____
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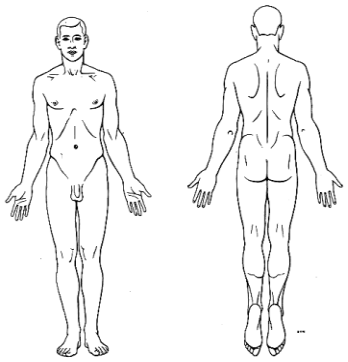

The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Acupuncture Associates **48** hours prior to any cancellations or changes to my appointment times and that if I do not I **will** be charged for the appointment.

X Signed: _____ Date: _____

Parent / Guardian (if applicable) _____

Would you like to receive a free email newsletter? ☐ Yes ☐ No