greatspring Acupuncture

Date:_____ **The information provided on this form is confidential**

Name_____ Date of Birth_____ Male ☐ Female ☐

Address_____ City_____ State_____ Zip_____

Phone _____ Email_____ Alt. Phone_____

Occupation_____ Are you: ☐ Married/Stable Relationship ☐ Single ☐ Divorced ☐ Widowed

Emergency Contact (name and phone)_____

Physician (Name/Address)_____

Physician Phone_____ Referred by_____

Main issue(s) you would like addressed with acupuncture:_____

Other types of treatments you have used:_____

How long have you had these symptoms:_____ Onset was ☐ sudden ☐ gradual

What makes your symptoms better?_____ Worse?_____

Have you received a medical diagnosis? ☐ yes ☐ no If Yes, what is it?_____

Please list current medications:_____

Prior experience with acupuncture:_____

PAST MEDICAL HISTORY (Please Include Dates):

☐ AIDS/HIV _____	☐ Diabetes _____	☐ Latex Allergy _____	☐ Other _____
☐ Alcoholism/Addiction _____	☐ Emphysema _____	☐ Lyme Disease _____	☐ Polio _____
☐ Allergies _____	☐ Heart Disease _____	☐ Lymph Nodes Removed _____	☐ Seizures _____
☐ Asthma _____	☐ Hepatitis A/B/C _____	☐ Multiple Sclerosis _____	☐ Stroke _____
☐ Cancer _____	☐ High/Low Blood Pressure_____	☐ Pacemaker _____	☐ Thyroid Imbalance _____

Please note any **surgeries** or **hospitalizations**, the date and outcome:

_____

_____

_____

Please note any **accidents** or **injuries** and the dates:

_____

_____

_____

FAMILY MEDICAL HISTORY Please note any significant family illnesses and age at death:

Mother:_____ Father: _____

Siblings_____

Grandparents:_____

LIFESTYLE :

Please describe your meals during a typical day:

Breakfast_____ Lunch_____

Dinner_____ Snacks_____

Any Food Cravings?_____ Any Food Intolerance?_____

Please list any vitamins/supplements you are taking?_____

How often do you have the following: Meat_____ day Poultry _____ day Fish _____ day

Sugar/Sweets_____ day Dairy (milk, cheese, yogurt) _____ day Vegetables/Fruits_____ day

How much do you have of the following: Water_____ oz Soda_____ oz Alcohol _____ oz Juice _____ oz

Coffee _____ oz Tea (including herbal) _____ oz

How would you describe your energy level? _____

What time of day is it highest? _____ Lowest? _____

Do you exercise? _____ How Often? _____ What kind of exercise do you do? _____

Do you smoke? □ yes □ no How much?_____

EMOTIONS & SLEEP:

How do you feel emotionally? _____

Circle TWO emotions which predominate your life: Anger Depression Happiness Worry Fear Overthinking Grief/Sadness

How do you handle your stress?_____ How do you relax?_____

How would you rate your stress level: _____ List any major stressors:_____
(1 little or no stress to 10 high stress)

How long do you normally sleep? _____ Hours a night Do you feel rested upon waking? _____

Do you have any of the following (please check all those that apply):

SLEEP

□ Trouble Falling Asleep
□ Trouble Staying Asleep
□ Disturbed Sleep
□ Waking up at _____am/pm and not able to fall asleep again because _____
□ Vivid Dreams/Nightmares

SKIN & HAIR

□ Rashes
□ Ulcerations
□ Hives/Allergic Dermatitis
□ Itching
□ Eczema/Psoriasis
□ Acne
□ Dandruff
□ Loss of Hair
□ Dry Skin
□ Purpura
□ Premature Graying
□ Other_____

GENERAL

□ Appetite: Strong / Poor
□ Aversion to Heat / Cold
□ Bleed/Bruise Easily
□ Cold Hands / Feet
□ Chills
□ Generally I feel HOT or COLD
□ Fevers
□ Night Sweats
□ Sweat Easily/A lot
□ Peculiar Tastes/Smells
□ Sudden Drop in Energy at _____
□ Tremors
□ Thirst Weak / Strong
□ Trauma/PTSD

IMMUNE SYSTEM

□ Repeated colds
□ Cold of more than 7 days
□ Repeated Infections
□ Other_____

EMOTIONS & THOUGHTS

□ Anxiety/Panic Attacks
□ Depression
□ Seasonal Affective Disorder
□ Bad Temper
□ Irritability
□ Worry a lot
□ Difficulty Concentrating
□ Poor Memory
□ Other_____

CARDIOVASCULAR:

□ Blood pressure: LOW HIGH
□ Blood clots
□ Chest pain
□ Palpitations
□ Irregular heart beat
□ Phlebitis
□ Cold hands & feet
□ Varicose Veins/Spider Veins
□ Other:_____

Have you been diagnosed with Heart trouble? □ Yes □ No

GASTROINTESTINAL
- Belching
- Nausea
- Vomiting
- Vomiting of Blood
- Ulcers
- Bloating
- Acid Reflux
- Heartburn
- Hernia
- Indigestion
- Severe Stomach Pains
- Other_____

Bowel Movements:
How often? _____day/wk
Painful Bowel Movement: Yes No
- Irregular
- Constipation
- Diarrhea
- Gas
- Burning
- Hemorrhoids
- Undigested Food in Stool
- Loose Stool
- Hard Stool
- Blood in Stool
- Itchiness
- Use of Laxatives
- Other:_____

GENITO-UNRINARY
Urination: How often? _____ times /day
Color: Pale Yellow
Yellow Dark / Orange
- Pain on Urination
- Frequent Urination
- Trouble Starting Stream
- Incontinence
- Burning
- Unable to Hold Urine
- Blood in Urine
- Kidney Stones
- Urinary Tract Infections
- Other_____
- Wake up to urinate:

How often _____/night; time _____
- Low Libido

MALE
- Infertility
- Impotence
- Prostrate problems
- Lumps in testicles
- Nocturnal Emission
- Other_____

FEMALE REPRODUCTIVE
Are you currently pregnant? Yes No
Trying to get Pregnant? Yes No
- Irregular Menstruation
- Heavy Flow
- Light Flow
- No Flow
- Clots
- Spotting between periods
- Discomfort/Pain before period
- Discomfort/Pain during period
- Vaginal Itching/Burning
- Uterine Fibroids
- Vaginal Discharge
- Menopause Age _____

Symptoms_____
_____
- Breast Tenderness
- Discharge from breast
- PMS
- Infertility If yes, what is your diagnosis?_____

_____
Age at first menses:_____
Number of Days between cycle:_____
Number of days of flow:_____
Color:_____
Date of last menstrual period:
_____
Number of pregnancies:_____
Number of deliveries:_____
Number of miscarriages:_____
Number of abortions: _____

Do you practice birth control? Yes No
What type?_____

MUSCLES, JOINTS, & BONES
- Swollen joints
- Arthritis/joint pain
- Tendinitis
- Rheumatism
- Bone Pain
- Muscle Pain
- Muscle Cramping
- Repetitive Strain Injury
- Neuropathy
- Other pain or tightness, location:_____

Quality of pain is:
Sharp Aching Throbbing
Deep Burning Dull
Tingling Stabbing Sore

Constant Radiating Fixed
Comes & goes Moves about

HEAD, EYES, EARS, NOSE, & THROAT:
- Dizziness
- Concussions
- Poor Vision
- Glasses
- Eye Pain
- Night Blindness
- See Spots
- Cataracts
- Blurred Vision
- Earaches
- Poor Hearing
- Tinnitus
- Sinus Problems
- Vertigo
- Frequent Sore Throat
- Dry Mouth
- Bleeding Gums
- Sores in mouth /on lips
- Grinding Teeth
- Facial Pain
- Nose Bleeds
- Headaches/Migraines (please describe):_____
_____
_____
- Other_____

RESPIRATORY
- Cough
- Coughing up blood
- Asthma
- Shortness of breath
- Cough up mucus
- Other_____

ENERGY
- Physical Fatigue
- Mental Fatigue
- Sudden drop in energy
- Restlessness
- Hyperactivity
- Poor Stamina
- Other_____

PLEASE COMPLETE IF YOU ARE SEEKING TREATMENT FOR PAIN:

Please describe your pain level (0 no pain at all to 10 being the worst): 0……1…...2…...3…...4…...5……6…...7…...8…...9…...10

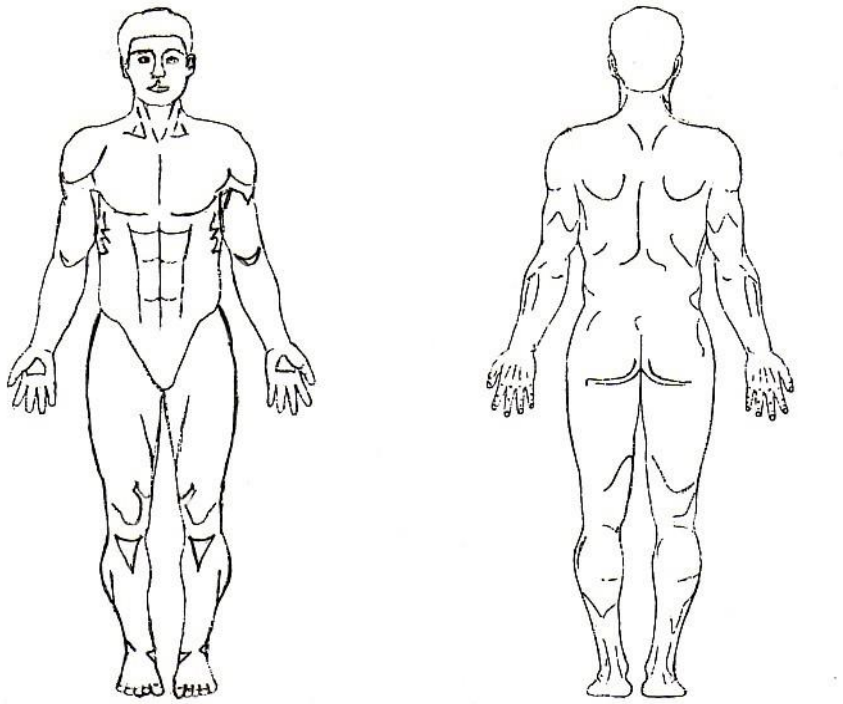
How long have you had pain? _____ years _____ months _____ days
Has surgery been performed on the site(s)? yes no

How does the pain impact your daily life?_____

_____

Using the letters at the bottom of the page to describe your discomfort, indicate directly on the figures in the exact area you are experiencing discomfort.

SHADE IN PAINFUL OR DISTRESSED AREAS:



D - Dull	S - Sharp	C – Cramping	B – Burning
R – Radiating	M- Moves about	N – Numbness	T – Tingling
X – Scars from injury or surgery	A - Aching	O – Rashes, Skin Disorders	Other: