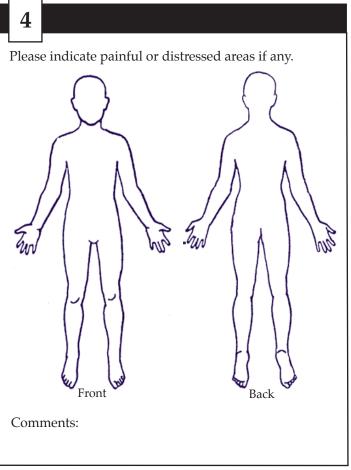
Welcome to acupuncture!



1 PATIENT INFORMATION	2 CONTACT INFORMATION		
Date	Cell phone		
Name	Home phone		
Address	. Work phone		
City State Zip	Email		
Age Birthdate	Best time and place to reach you		
Occupation			
Primary physician	Another person whom we may contact if needed:		
Physician phone number	Name		
Whom may I thank for referring you?	Relationship		
	Phone		
MEDICATIONS / LUCTORY			

3	MEDICATIONS / HISTORY				
List medications or food supplements you are taking.					
List serious illnesses, accidents or surgeries.					
2.50 serious anticoses, acciueras er surgeries.					
Check illnesses that have occurred in blood relatives.					
	etes High blood pressure Stroke				
∐ Cance	er Heart disease Kidney disease				
Check il	etes High blood pressure Stroke				



5 HEALTH HISTORY						
Check symptoms you now have or have had in the last year.						
□ Depression □ Difficulty in focusing □ Dizziness □ Easily startled □ Excessive worry □ Excessive anger □ Excessive fear □ Fatigue/tiredness □ Headaches □ Loss of sleep/poor sleep □ Loss or gain of weight □ Nervousness/irritability □ Overwhelmed by life MUSCLE/JOINT/BONES □ Tremors □ Cramps □ Swollen joints Pain, weakness, numbness in □ Arms □ Hips □ Back □ Legs □ Feet □ Neck □ Hands □ Shoulders	GASTROINTESTINAL Belching, gas or bloating Colon trouble Constipation Diarrhea Difficulty swallowing Distention of abdomen Excessive hunger Gall bladder trouble Hemorrhoids (piles) Indigestion Nausea Pain over stomach Poor appetite Vomiting CARDIOVASCULAR Chest pain Hardening of arteries High or low blood pressure Pain over heart Poor circulation Previous heart attack Rapid/irregular heart beat Swelling of ankles	EENT/RESPIRATORY Asthma/wheezing Blurred or failing vision Difficulty breathing Earache En larged glands Eye pain Frequent colds Hay fever Hoarseness Gum trouble Nose bleeds Loss of hearing Persistent cough Ringing in ears Sinus problems SKIN Boils Bruise easily Dry skin Itching/rash Sensitive skin Sore won't heal Sweats	GENITO/URINARY Blood/pus in urine Frequent urination Inability to control urine Kidney infection/stones Lowered libido FOR MEN ONLY Erection difficulties Penis discharge Prostate trouble FOR WOMEN ONLY Bleeding between periods Clots in menses Excessive menstrual flow Extreme menstrual pain Irregular cycle Menopausal symptoms PMS Previous miscarriage Scanty menstrual flow Could you be pregnant?			
Check conditions you have or AIDS Allergies Anemia Arthritis Bleeding disorders Breast lump Cancer Diabetes	have had in the past. Eczema Emphysema Heart disease Hepatitis Herpes HIV positive Kidney disease	Pneumonia Rheumatic fever Scarlet fever Seizures Stroke Thyroid disease Tuberculosis Ulcers	How long has it been since you have had a complete medical exam?			
Check which substances you use and describe how much you use. Caffeine Drugs Alcohol Tobacco Sugar		Check if your work or lifestyle exposes you to these. Stress Insufficient sleep Very long working hours Long commuting times Heavy lifting or hazardous substances Other				
7 SIGNATURE The information on this form is correct to the best of my knowledge. I understand that my protected health information will be used and disclosed consistent with the policies in this office's Notice of Privacy Practices.						
Signature	Date					