Acupuncture New Client Information

Name_____
Address_____
_____
_____
Home phone _____
Work or cell phone _____
Email_____
Birth date _____Age _____

Gender _____ Preferred Pronoun(s)_____
Number of children_____Ages _____
Marital status _____
Occupation _____
Referred by _____
Primary physician name _____
Emergency contact name _____
Relationship _____Phone _____

Your Health

Please tell me about the **main problem** that brings you in today

Symptoms / Disease:	How long?

Have you received an MD diagnosis for this concern? If yes, what was the diagnosis? _____
_____

What kinds of treatment(s) have you tried or are currently using related to this concern? _____
_____

Please mark the severity of your chief concern today.
No problem _____Worst imaginable

1 2 3 4 5 6 7 8 9 10

Please tell me about **any other concerns** you might like to tackle

Symptoms / Disease:	How long?

Personal Medical History

Please mark all that apply and explain as necessary.

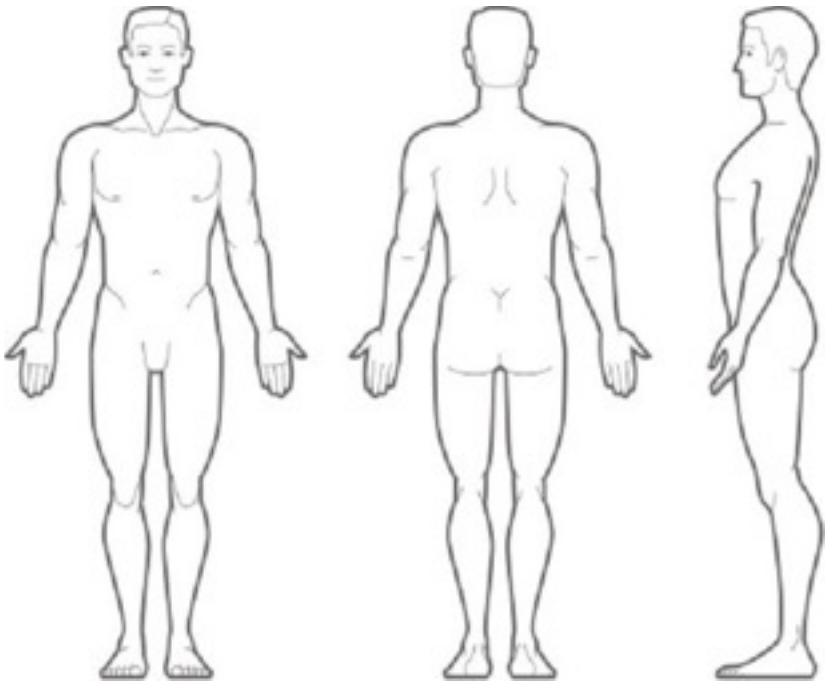
▫ Allergies	▫ Heart disease	▫ Seizures
▫ Asthma	▫ Hepatitis	▫ Stroke
▫ Cancer	▫ High blood pressure	▫ Thyroid disease
▫ Diabetes	▫ HIV/AIDS	▫ Other

Date and describe past hospitalizations & surgeries:

Date and describe major traumas:

List all known allergies (food, chemicals, drugs, seasonal, insects, etc.)_____

Pain patient? Please circle or mark where you have pain. Feel free to include other info about it in the margins:



Review of Symptoms

Please mark “Past” if you've had any symptom in the past 4 years.
Please mark “Current" if you have them currently or in the past 2 months.

General

Past	Current	
☐	☐	Catch cold easily
☐	☐	Recurrent infections
☐	☐	Night sweats
☐	☐	Bleed or bruise easily
☐	☐	Strong thirst (hot or cold)
☐	☐	Fatigue/low energy
☐	☐	Weight loss
☐	☐	Weight gain

Skin and Hair

Past	Current	
☐	☐	Dry skin/scalp/hair
☐	☐	Rashes/hives
☐	☐	Itching
☐	☐	Eczema
☐	☐	Acne
☐	☐	Change in moles
☐	☐	Hair loss/thinning hair
☐	☐	Graying of hair

Sleep

Past	Current	
☐	☐	Difficulty falling asleep
☐	☐	Wake up easily during the night Times per night?
☐	☐	Wake up too early in the am
☐	☐	Nightmares
☐	☐	Vivid dreams
☐	☐	Grinding teeth
☐	☐	Talking in sleep
☐	☐	Snoring

Circulation

Past	Current	
☐	☐	Cold hands or feet
☐	☐	Swelling of hands/feet
☐	☐	Blood clots
☐	☐	Varicose veins
☐	☐	Edema/swollen ankles

Head, Ears, Eyes, Nose, Throat

Past	Current	
☐	☐	Headaches
☐	☐	Migraines
☐	☐	Dizziness/vertigo
☐	☐	Fainting spells
☐	☐	Earache
☐	☐	Change in hearing
☐	☐	Ringing in the ears
☐	☐	Blurry vision
☐	☐	Night blindness
☐	☐	Spots before eyes
☐	☐	Dry eyes
☐	☐	Eye pain/sore eyes
☐	☐	Excessive tearing
☐	☐	Glasses/contacts
☐	☐	Facial pain
☐	☐	Facial paralysis
☐	☐	Nosebleeds
☐	☐	Blocked nose/sinuses
☐	☐	Sinus infections
☐	☐	Jaw pain
☐	☐	Teeth/gum problems
☐	☐	Recurrent sore throat
☐	☐	Hoarseness/loss of voice
☐	☐	Tonsillitis/swollen glands
☐	☐	Sores on lips/mouth/gums
☐	☐	Strange taste in mouth
☐	☐	Swollen glands/lumps
☐	☐	Oral ulcers
☐	☐	Other

Nervous System

Past	Current	
☐	☐	Loss of taste/smell/touch
☐	☐	Tingling sensations/numbness
☐	☐	Tremors
☐	☐	Lack of coordination/balance
☐	☐	Paralysis or seizures
☐	☐	Stroke
☐	☐	Concussion

Chest

Past	Current	
☐	☐	Pain in chest
☐	☐	Tightness or pressure in chest
☐	☐	Pain with breathing
☐	☐	Difficulty breathing
☐	☐	Shortness of breath
☐	☐	Recurrent/chronic cough
☐	☐	Asthma/wheezing
☐	☐	Production of phlegm
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Heart palpitations or rapid heartbeat
☐	☐	Irregular heartbeat
☐	☐	Other

Digestion

Past	Current	
☐	☐	Little appetite
☐	☐	Strong appetite
☐	☐	Hunger but no desire to eat
☐	☐	Food cravings
☐	☐	Belching
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Heartburn
☐	☐	Indigestion
☐	☐	Abdominal pain
☐	☐	Regurgitation
☐	☐	Loose stools/diarrhea
☐	☐	Dysentery
☐	☐	Strong smelling stools
☐	☐	Blood in stools
☐	☐	Constipation (< 1 b.m./day)
☐	☐	Alternating constipation and diarrhea
☐	☐	Gas/flatulence
☐	☐	Hernia
☐	☐	Rectal pain/prolapse
☐	☐	Hemorrhoids
☐	☐	Anorexia nervosa
☐	☐	Bulimia
☐	☐	Bad breath

Urinary

Past Current

- ☐ ☐ Pain on urination
- ☐ ☐ Urgent urination
- ☐ ☐ Frequent urination
- ☐ ☐ Blood in urine
- ☐ ☐ Cloudy urine
- ☐ ☐ Dribbling urination
- ☐ ☐ Urinary incontinence/retention
- ☐ ☐ Incontinence at night
  - ☐ Do you wake to urinate? How many times?
- ☐ ☐ Bladder/kidney infections
- ☐ ☐ Recurrent yeast infections
- ☐ ☐ Kidney stones

Muscles and Joints

Past Current

- ☐ ☐ Neck pain
- ☐ ☐ Shoulder pain
- ☐ ☐ Back pain
  Where:
- ☐ ☐ Hand/wrist pain
- ☐ ☐ Knee pain
- ☐ ☐ Foot/ankle pain
- ☐ ☐ Joint/bone problems
- ☐ ☐ Muscle pain/weakness
- ☐ ☐ Tremors/tics in muscles
- ☐ ☐ Osteoporosis
- ☐ ☐ Herniated disc
- ☐ ☐ Sciatica

Mind and Emotions

Past Current

- ☐ ☐ Poor memory
- ☐ ☐ Difficulty concentrating
- ☐ ☐ Depression
- ☐ ☐ Often stressed
- ☐ ☐ Lose control of emotions
- ☐ ☐ Substance abuse
- ☐ ☐ Anxiety/nervousness
- ☐ ☐ Manic behavior
- ☐ ☐ Panic attacks
- ☐ ☐ Easily angered
- ☐ ☐ Aggressive behavior

Male System

Past Current

- ☐ ☐ Prostate problems
- ☐ ☐ Change in sexual drive
- ☐ ☐ Rashes/itching
- ☐ ☐ Genital discharge
- ☐ ☐ Erection difficulty
- ☐ ☐ Low sperm count/motility

Female System

Could you be pregnant now?
☐ Yes ☐ No

Are you trying to get pregnant?
☐ Yes ☐ No

Do you practice birth control?
☐ Yes ☐ No

What type and for how long?
_____

Number Of:
Pregnancies ___ Miscarriages ___
Births___ Abortions____

Age of First Period?_____
Date Of Last Period? _____
Number of days per cycle? _____

Past Current

- ☐ ☐ Premenstrual irritability
- ☐ ☐ Clots in menstrual blood
- ☐ ☐ Irregular menses
- ☐ ☐ Painful menses
- ☐ ☐ Heavy/prolonged bleeding
- ☐ ☐ Missed menses
- ☐ ☐ Spotting/abnormal bleeding
- ☐ ☐ Vaginal discharge
- ☐ ☐ Vaginal dryness
- ☐ ☐ Genital sores
- ☐ ☐ Ovarian cysts
- ☐ ☐ Fibroids
- ☐ ☐ Endometriosis
- ☐ ☐ Breast swelling or redness
- ☐ ☐ Nipple discharge
- ☐ ☐ Abnormal Pap smear
- ☐ ☐ Infertility
- ☐ ☐ Other

Daily Routines

Sleep

Usual Time Awaken _____ Usual Bed Time _____ Avg. hours of sleep/night _____

Meals

Typical Breakfast _____

Typical Lunch _____

Typical Dinner _____

Do you exercise regularly? Yes_____ No_____ Length of time_____ Times per week _____

Types(s) of exercise _____

How many hours per week do you work?_____ How far is your commute? _____

Other comments about your daily routine _____

General Habits

Are you a vegetarian or vegan? Yes_____ No_____ If yes, how long _____

What are the major stressors in your life? _____

Current Prescription Medicines:

_____

_____

_____

_____

Current over the counter medicines & supplements:

_____

_____

_____

_____

Please mark your current use levels of the following:

Tobacco ▫ Number of cigarettes per day_____ Age started _____

Alcohol ▫ Number of drinks per week_____ Type of drinks _____

Caffeine ▫ Number of cups per day_____ Type of drinks _____

Do you have any current or past problems with addiction or substance abuse? Yes_____ No_____

Substance(s)_____ When did you quit? _____

Signature_____ **Date**_____