# Family Room
## Community Acupuncture

**Patient Information**

Date of First Visit _____

Name _____

Address _____

City State Zip _____

Age _____ Birthdate _____

Preferred Pronoun She He Other _____

Occupation _____

Primary physician _____

**Contact Information**

Best phone # _____

Alternate phone # _____

Email _____

Another person we may contact in case of emergency:

Name/Relationship _____

Phone _____

How did you hear about us? _____

Are you new to acupuncture? Yes ___ No ___

**Health History**

What are your primary concerns/complaints?

1) _____

Onset: _____ Severity: _____

2) _____

Onset: _____ Severity: _____

3) _____

Onset: _____ Severity: _____

How is your sleep? _____

How would you describe your energy level?

_____

How is your digestion? _____

List medications, supplements or herbs you are taking

_____

_____

Are you taking blood thinners? Yes ___ No ___

List serious accidents or surgeries: _____

_____

_____

Are you pregnant? Yes ___ No ___

Are you interested in taking Chinese Herbs?
Yes ___ No ___ Maybe ___

Check conditions you have now or have had in the past:

- ☐ HIV+/AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer _____
- ☐ Autoimmune Disorder _____
- ☐ Bleeding Disorder
- ☐ Diabetes 1 or II
- ☐ Heart disease
- ☐ Hepatitis B or C
- ☐ High blood pressure Controlled? Yes ___ No ___
- ☐ Pacemaker
- ☐ Stroke
- ☐ Erection difficulties
- ☐ Prostate trouble
- ☐ Low libido
- ☐ Hemorrhoids
- ☐ Herpes
- ☐ PMS
- ☐ Fibroids
- ☐ Miscarriages
- ☐ Meno/perimenopause symptoms _____
- ☐ Severe allergies _____

Is there anything else you'd like us to know about you?

_____

_____

| **Acupuncturist's Notes:** |
| --- |
| **T:** |
| **P:** |
| |
| |

## Health History

Check symptoms you have or have had in the last year:

### MUSCLE/JOINT/BONES

- ☐ Tremors c Cramps
- ☐ Swollen joints

Pain, weakness, numbness in:

- ☐ Arms or Hips
- ☐ Back Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders
- ☐ Other _____

### 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

### EYES/EAR/NOSE/THROAT/RESPIRATORY

- ☐ Asthma/wheezing
- ☐ Blurred or failing vision
- ☐ Difficulty breathing
- ☐ Earache
- ☐ Enlarged glands
- ☐ Eye pain
- ☐ Frequent colds
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Gum trouble
- ☐ Nose bleeds
- ☐ Loss of hearing
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems

### 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

### SKIN

- ☐ Boils
- ☐ Bruise easily
- ☐ Dry skin
- ☐ Itching/rash
- ☐ Sensitive skin
- ☐ Sore won't heal
- ☐ Sweats

### FOR MEN ONLY

- ☐ Erection difficulties
- ☐ Penis discharge
- ☐ Prostate trouble

### GENITO/URINARY

- ☐ Blood/pus in urine
- ☐ Frequent urination
- ☐ Inability to control urine
- ☐ Kidney infection/stones
- ☐ Lowered libido

### 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?

## Signature

The information on this form is correct to the best of my knowledge.

_____ _____

signature date