9085 E Mineral Circle Ste 255
Centennial, CO 80112
720.291.3102

Confidential – New Patient

Information Sheet

Contact Information

Name: ______________________________ Date: ______________

Address: ______________________________

City: ______________________ State: ______ Zip: ______

Home Phone: __________________ Mobile: ______________________

Email: ______________________ Work Phone: ____________________

I wish to be contacted in the following manner (check all that apply)

__Home Phone __Work Phone
__Email __Written

May we **Email Text** Neither to remind you of your upcoming appointments? Y N
(Circle)
Would you like to receive email regarding clinic discounts and special events? Y N

How did you hear about us? ______________________________

Generally, Acu Health And Beauty does not release protected health information (PHI) and/or sensitive health information over the phone, via electronic mail, or via written communication. If we need to communicate PHI to you we will contact you to schedule a consultation treatment.

From time to time we may phone, email or post general information such as updates and alerts, notification of clinic deals, and reminders of upcoming appointments. If you do not wish for us to use a specific form of communication, please indicate below.

__I would not like to receive general communications via telephone (including appointment reminders.)
__I would not like to receive general communications via email.
__I would not like to receive general communications via mail delivery.

Patient Information

Name: ______________________________ DOB: __________

Height: ________ Weight: ________ Age: _________ Marital Status: _________

Number of Children: _________ Occupation: ______________________________

Employer: ______________________________

Emergency Contact: ______________________ Phone Number: ______________

Medical Complaint

Reason for your visit here today: ____

____

How long have you had this condition? ____

Have/are you being treated for this condition by anther health care practitioner? ____________________

Have these treatments helped? Y N

Has this condition been diagnosed by a MD? Yes Diagnosis: ____________________ No

Have you consulted with a MD? Y N

Have you had acupuncture before? Y N

Do you currently have any infectious diseases? Y N

If Yes, please identify: ______________________________________

Medical History

Please check all that apply currently and circle if a previous condition:

Cardiovascular Conditions:
__Heart Disease
__Heart Attack
__A Pacemaker
__High Blood Pressure
__Low Blood Pressure
__Chest Pain
__Palpitations
__Stroke
__Varicose Veins
__Edema

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

Liver Conditions:
__Hepatitis A
__Hepatitis B
__Hepatitis C

Neurological:
__Vertigo/Dizziness
__Paralysis
__Numbness/Tingling
__Loss of Balance
__Seizures/Epilepsy
__Dyslexia
__Insomnia
__Poor Memory

Emotional/Mental:
__Anxiety/Fear
__Anger/Frustration
__Grief/Sadness
__Lack of Joy/Mania
__Worry/Over-thinking
__Clinical Depression
__Mild Depression
__ADD or ADHD
__Panic Attacks
__Alzheimer's
__Dementia

Head, Eye, Ear, Nose and 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

Energy and Immunity:
__General Fatigue
__Slow Wound Healing
__Easy Bruising
__Chronic Infections
__Frequent Allergies

Genito-Urinary Tract:
__Kidney Disease
__Kidney Stones
__Painful Urination
__Dribbling Urination
__Frequent UTI
__Frequent Urination
__Blood in Urine
__Discharge
__Incontinence

Endocrine:
__Hypothyroid
__Hypoglycemia
__Hyperthyroid
__Diabetes Type I
__Diabetes Type II
__Night Sweats
__Unusual Sweating
__Feeling Hot or Cold

Respiratory:
__Pneumonia
__Asthma
__Frequent Common Colds
__Difficulty Breathing
__Emphysema
__Persistent Cough
__Pleurisy
__Tuberculosis
__Shortness of Breath

Skin
__Rashes
__Warts
__Moles
__Acne
__Cosmetic Surgery
Contagious? Y N

Gastrointestinal:
__Stomach Ulcers
__Changes in Appetite
__Nausea/Vomiting
__Epigastric/Abdominal Pain
__Passing Gas
__Heartburn
__Belching
__Gall Bladder Disease
__Gall Bladder Stones
__Hemorrhoids
__Indigestion
__Constipation
__Diarrhea
__Irritable Bowel Syndrome
__Leaky Gut Syndrome

Other:
__Cancer
Type:
__Fibromyalgia
__Lupus
__Candida
__Anemia
__Rashes
__Eczema/Hives
__Hemophilia
__Significant Trauma
Type:
__Significant Dental Work
__Alcoholism
__Aids/HIV
Childhood Illnesses
__Chicken Pox
__Measles
__Mumps

Break in Skin? Y N

Allergies or Pharmaceutical Reactions:

Surgical History:

Medical History (Continued)

Family History:

__Asthma __Cancer __Diabetes __Heart Disease
__Obesity __Stroke __Hypertension

Anything Else Significant:

Men Only:

__Impotence __Painful Intercourse __Vasectomy Date: ___________
__Excessive Libido __Seminal Emissions
__Low Libido __Prostate Problems __Testicular Pain/Redness/Swelling

Women Only

Are you pregnant (Circle)? Y N Birth Control Method: ______________________
Age of 1st period: _____ Age of Menopause: _____
1st Day of last menses: __________
Number of Pregnancies: _____ Births: _____
Hysterectomy (Circle): Full Partial Date: __________ No

Check all that apply:

__Painful Periods __Low Libido __Painful Intercourse __Clotting
__Irregular Cycles __Excessive Libido __Scanty Flow __Inter-Cycle Bleeding
__Infertility __Vaginal Discharge __Breast Tenderness __Nipple Discharge
__Fibroids __Moodiness __PMS __Endometriosis
__Heavy Flow __Fibrocystic Breasts __Ovarian Cysts __Abnormal Pap Smear

Supplements, Herbs, Vitamins

Please list all current supplements, herbs, medications and the reason you are taking:

___

___

___

___

Lifestyle

How would you rate the following in the past month: 1= Poor 10= Excellent

Health	1 2 3 4 5 6 7 8 9 10	Comments: ____________
Energy	1 2 3 4 5 6 7 8 9 10	Comments: ____________
Stress	1 2 3 4 5 6 7 8 9 10	Comments: ____________
Exercise	1 2 3 4 5 6 7 8 9 10	Comments: ____________
Sleep	1 2 3 4 5 6 7 8 9 10	Comments: ____________
Mood	1 2 3 4 5 6 7 8 9 10	Comments: ____________
Immunity	1 2 3 4 5 6 7 8 9 10	Comments: ____________

Check all that apply:

__Vegetarian
__Vegan __Caffeine How much? ________ How Often? __________
__Restricted Diet __Drink Alcohol How much? ________ How Often? __________
__Recreational Drugs __Smoke How Much? __________ How Long have you smoked? _________