Healing Hands Acupuncture

Confidential Acupuncture Patient Information

Name_____ Date_____

Address_____Email_____

Phone numbers (home)_____ (work)_____

(cell)_____ (emergency)_____

Who may I thank for referring you?_____

Date of birth_____ Sex_____ Age_____ Marital status_____ Number of children_____

Occupation_____ Hobbies_____

Responsible party (if not patient)_____ relationship_____

Primary care physician_____ phone_____

Last Physical Exam: Date_____ Doctor_____

Height_____ Weight_____ Recent changes?_____

ALL Current diagnoses_____

_____

Complaint (please rank by priority)	Onset	Frequency	Severity
Example: headaches	*07/01*	*X times/ week*	*mild/ moderate/ severe*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What other treatments have you tried, and what has been your response?

_____

_____

Medicines taken within the past two months: (include vitamins, over-the-counter drugs, herbs, etc)

_____

_____

Occupational stresses: (chemical, physical, psychological, etc)_____

Lifestyle: Indicate quantity, type, and frequency:

Alcohol_____ Coffee_____ Tea_____

Tobacco_____ Sweets_____ Sodas_____

Water_____ Exercise_____ Drugs_____

Typical daily diet_____

_____

Food cravings: sour_____ bitter_____ sweet_____ spicy_____ salty_____ other_____

Healing Hands Acupuncture

Confidential Acupuncture Patient Information

Current health issues:

_____poor appetite _____strong appetite _____strong thirst (hot or cold drinks?)_____

_____poor sleep _____heavy sleep _____insomnia _____fatigue _____tremors

_____vertigo _____localized weakness _____poor coordination _____cold hands ____cold feet

_____cold back _____cold abdomen _____fevers _____chills _____night sweats

_____sweat easily _____bleed or bruise easily (where) _____ _____sudden energy drop at _____(time)

_____allergies: what kind (food, medications, respiratory) _____

Head, Eyes Ears, Nose, Throat

_____dizziness _____migraines _____dry eyes _____glasses _____eye strain

_____eye pain _____poor vision _____blurry vision _____cataracts _____night vision

_____color blindness _____spots in eyes _____earaches _____ringing in ears

_____poor hearing _____ear infection _____nose bleeds _____sinus problems

_____mucus _____allergies _____dry throat _____dry mouth _____snoring

_____copious saliva _____sores in/on mouth_____teeth problems _____gum problems

_____jaw clicks _____grinding teeth _____recurrent sore throats_____/month _____facial pain

_____headaches (where and when) _____

Skin and hair:

_____rashes _____ulcerations _____hives _____itching _____hair loss

_____eczema _____pimples _____dandruff _____change in skin/ hair texture

_____herpes (where) _____ other hair or skin problems_____

Respiratory:

_____cough _____coughing blood _____asthma _____bronchitis _____tight chest

_____pneumonia _____difficulty breathing while lying down _____production of phlegm

other respiratory problems_____

Cardiovascular:

_____high blood pressure _____/_____ _____low blood pressure _____/_____

_____irregular heart beat/ palpitations _____chest pain _____dizziness _____fainting

_____swelling in hands/ feet _____blood clots_____phlebitis _ ____difficulty breathing

other cardiovascular_____

Gastrointestinal:

_____nausea _____vomiting _____diarrhea _____gas _____food allergy

_____belching _____black stools _____heartburn _____bad breath_____bloating

_____rectal pain _____hemorrhoids _____constipation _____bloody stool

_____tenderness in abdomen _____laxative use/ frequency_____ _____pain or cramps

stools: _____frequency _____color _____odor _____texture/ form

other gastrointestinal problems_____

Healing Hands Acupuncture

Confidential Acupuncture Patient Information

Urogenital:

_____pain on urination _____frequent urination _____blood in urine _____urgency to urinate

_____unable to hold urine _____kidney stones _____urinary infection _____venereal disease

_____impotency _____wake up to urinate how often?_____ per night_____ time of night

other urogenital_____

Pregnancy and Gynecology:

_____number pregnancies _____number births _____premature births _____miscarriages

_____age at first menses _____irregular periods _____painful periods _____PMS _____perimenopausal

_____vaginal sores _____breast lumps _____vaginal discharge: color_____odor_____

_____age at menopause _____length of cycle (days) _____length of period (days) _____birth control, type,

duration of birth control_____ other gynecological_____

Musculoskeletal:

_____neck pain _____muscle pains _____tendonitis _____back pain

_____joint pains _____spasms/ cramps _____weakness (where_____)

_____osteoporosis _____broken bones _____broken teeth _____concussion

other bone, joint, or muscular problems_____

Neuropsychological:

_____seizures _____areas of numbness _____poor memory _____depression _____anxiety

_____bad temper _____easily stressed _____moodiness _____treated for emotional problems

_____considered/ attempted suicide other neurological or psychological problems_____

History: Significant illnesses: _____cancer _____diabetes _____high blood pressure _____heart disease

_____hepatitis _____rheumatic fever _____thyroid disease _____seizures _____other (include any which made

you very ill, had high fever, recurred, required hospitalization, or took long to resolve)

_____

Trauma: List any injuries, dislocation, head trauma, loss of consciousness, sprains, fractures, or burns

_____

_____

Surgeries: _____

_____

Family medical history:

_____heart problems _____hypertension _____diabetes _____stroke

_____kidney disease _____cancer _____breathing problems _____TB/ tuberculosis

_____seizures _____mental illness _____addiction _____thyroid disease

_____allergies _____arthritis _____other_____