Piedmont Acupuncture & Wellness Clinic

Patient Information

Name:					
	First	Middle	Last		
Address:					
	Street		City	State	Zip
Phone:			Email:		
Age:	DOB:		Gender:		
Marital Status:	Single	Married	Divorced	Separated	Widowed	Domestic Partnership
Occupation:			Employer:		
Emergency Contact:					
	Name		Phone#		Relationship

Primary Treating Physician		
	Name	Phone#
Ob/Gyn		
	Name	Phone#
Other Provider		
	Name	Phone#
Other Provider		
	Name	Phone#

Referred By:	
Name	Phone#

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Have you had acupuncture before? Y / N Date:

(Please provide any additional information on the back of this page)

Health History

Name:_____ Today's Date:_____

DOB:_____ Height:_____ Weight:_____ Usual Blood Pressure:_____

Reason for Visit: Please list 4 major health concerns in order of importance and indicate level of impairment on a scale of 1-10 (1= no symptoms, 10=worst ever), how long you have been experiencing this and if there is anything that makes it better or worse (ie. cold/hot, movement/rest etc.)

1._____

1 5 10
Level of impairment: I------I------I------I------I------I------I------I------I------I------I For how long:_____

What makes it better:_____

What makes it worse:_____

2._____

1 5 10
Level of impairment: I------I------I------I------I------I------I------I------I------I------I For how long:_____

What makes it better:_____

What makes it worse:_____

3._____

1 5 10
Level of impairment: I------I------I------I------I------I------I------I------I------I------I For how long:_____

What makes it better:_____

What makes it worse:_____

4._____

1 5 10
Level of impairment: I------I------I------I------I------I------I------I------I------I------I For how long:_____

What makes it better:_____

What makes it worse:_____

Please list any Food or Drug allergies and reactions you have:

_____

_____

Please list any Medications with dosage (prescribed and over the counter) you are currently on:

_____

_____

Please list any Vitamins or Supplements you are currently taking:

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_____

_____

Please list any Surgeries & Hospitalizations (type and dates):

_____

_____

(Check all that apply)	Self	Mother	Father	Sibling	Children

Other:_____

_____

Do you have any Diet Restrictions? if so please describe

_____

_____

Please indicate your level of Stress on a scale of 1-10 (1=none, 10=worst ever)

1 5 10
I----------I----------I----------I----------I----------I----------I----------I----------I----------I

How does stress manifest for you (please list any physical/emotional symptoms):

_____

_____

What makes your stress worse?

_____

_____

What makes your stress better?

_____

_____

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Psychological/ Behavioral

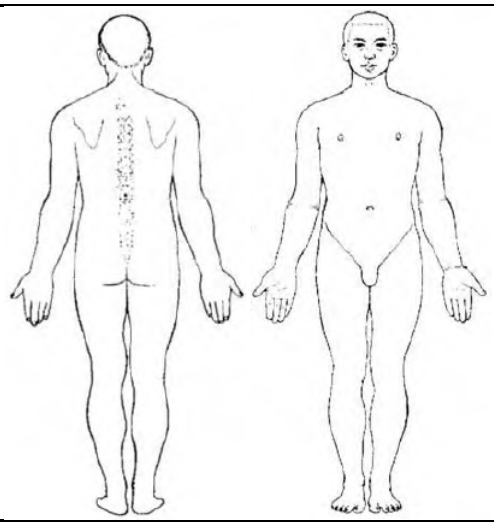
❑ Depression	❑ Aggressive Behavior	❑ Poor Memory/ Forgetful	❑ Easily Stressed
❑ Nervousness	❑ Fearful	❑ ADD/ADHD	❑ Lose Control of Emotions
❑ Anxiety	❑ Grief	❑ Bi-Polar	
❑ Panic Attacks	❑ Indecision	❑ Seasonal Affective Disorder	❑ Other:_____
❑ Irritable	❑ Poor Concentration	❑ Difficulty Expressing Emotions	
❑ Easily Angered	❑ Over Thinking	❑ Frequent Sighing/ Yawning	_____

Musculoskeletal

Please check all that apply:

❑ Pain
❑ Numbness
❑ Tingling
❑ Broken Bones
❑ Sprain/Strain
❑ Joint Swelling
❑ Edema
❑ Carpal Tunnel
❑ Tendonitis
❑ Restricted Movement
❑ Sciatica
❑ Herniated disk
❑ Osteoporosis
❑ Other:_____

❑ Head
❑ Neck
❑ Shoulders
❑ Arms
❑ Elbows
❑ Wrists
❑ Hands/Fingers
❑ Upper Back
❑ Middle Back
❑ Lower Back
❑ Hips
❑ Legs
❑ Knees
❑ Ankles
❑ Feet/Toes



(Please circle areas of concern)

Neurological

❑ Tremors	❑ Concussion	❑ Loss of Balance
❑ Paralysis	❑ Peripheral Neuropathy	❑ Vertigo/Dizziness
❑ Nerve Damage	❑ Significant Lack of Coordination	

Sleep

Sleep:_____hrs/ night **Wake**:_____x/night

❑ Difficulty Falling Asleep
❑ Difficulty Staying Asleep
❑ Excessive Sleep
❑ Not Enough Sleep
❑ Sleep Walk/Talk
❑ Disturbing Dreams
❑ Restless Sleep

❑ Not Rested Upon Waking
❑ Wake Too Early
❑ Sleep Apnea
❑ Grind Teeth
❑ Snoring
❑ Night Sweats
❑ Wake to Urinate

Energy

Please indicate on a scale of 1-10 your general level of energy and check all that apply

1 5 10
Low I-----I-----I-----I-----I-----I-----I-----I-----I-----I High

❑ Fatigue
❑ Wired
❑ Energy drop after eating
❑ Energy Drop: Time of Day:_____

❑ Other:_____

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❑ Shortness of Breath ❑ Slow Heart Rate ❑ Fast Heart Rate ❑ Palpitations	❑ Irregular Heart Beats ❑ Palpitations ❑ Varicose/Spider Veins ❑ Blood Clots	❑ Hand/Feet Swelling ❑ Fainting ❑ Bleed/Bruise Easily ❑ Chest Pain/Pressure	❑ Phlebitis ❑ High Blood Pressure ❑ Low Blood Pressure ❑Other:_____

Cardiovascular
Respiratory

❑ Pain with Breathing ❑ Difficulty Breathing ❑ Shallow Breathing ❑ Wheezing	❑ Production of Phlegm ❑ Recurrent/ Chronic Cough ❑ Shortness of Breath ❑ Chest Tightness	❑ Frequent Colds ❑ Frequent Fevers ❑ Cough Blood	❑ Bronchitis ❑ Emphysema ❑ Pneumonia ❑ Asthma

Gastro-Intestinal

Bowel Movement: How often? _____x/ _____ day(s)

❑ Indigestion ❑ Nausea/Vomit ❑ Bloating ❑ Belching ❑ Gas ❑ Feel a "lump" in the throat ❑ Heartburn/Reflux ❑ Bad Breath ❑ Excessive Saliva ❑ Poor Appetite	❑ Excessive Hunger ❑ Hunger but No Desire to Eat ❑ Hemorrhoids ❑ Bowel Incontinence ❑ Hiatal Hernia ❑ IBS/Crohns Disease ❑ Blood in Stool ❑ Rectal Pain ❑ Abdominal Pain ❑ Stomachaches	❑ Tired after BM ❑ BM Difficult to Pass ❑ Cramps w/ BM ❑ Incomplete BM ❑ Alternate Constipation/ Loose Stool ❑ Loose Stool ❑ Diarrhea ❑ Dry Stool ❑ Constipation ❑ Excessive Weight Gain ❑ Excessive Weight Loss

Genito-Urinary

❑ Dark Urine ❑ Clear Urine ❑ Cloudy Urine ❑ Burning Urine	❑ Scanty Urine ❑ Profuse Urine ❑ Frequent Urine ❑ Urgent Urine	❑ Blood in Urine ❑ Painful Urination ❑ Nocturnal Urination ❑ Difficult Start/Stop	❑ Frequent UTI ❑ Kidney Stones ❑ Incontinence

Hair, Skin, Nails

❑ Rashes ❑ Acne ❑ Dandruff ❑ Itching ❑ Warts	❑ Eczema ❑ Psoriasis ❑ Dermatitis ❑ Face Flushing ❑ Hives	❑ Thick Skin ❑ Scaly Skin ❑ Thin Skin ❑ Dry Skin ❑ Dry Nails	❑ Dark Under-eyes ❑ Abscesses/Infections ❑ Hair Loss ❑ Dry/Brittle Hair ❑ Premature Greying	❑ Weak Nails ❑ Ridged Nails ❑ Change in Hair/Skin Texture ❑ Other_____ _____

Dry I-----I-----I-----I-----I-----I-----I-----I-----I-----I Oily

Head, Eyes, Ears, Nose, Throat

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❑ Migraines	❑ Night Blindness	❑ Nose Bleeds	❑ Dry Lips/Mouth
❑ Headaches	❑ Glasses	❑ Poor Smell	❑ Dry Throat
❑ Facial Pain	❑ Spots in Eyes	❑ Sinus Problems	❑ Difficulty Swallowing
❑ Heavy Headed	❑ Eye Strain	❑ Nasal Discharge	❑ Sore Throats
❑ Light Headed	❑ Eye Pain	❑ Poor Hearing	❑ Lip/Mouth Sores
❑ Dizziness	❑ Red Itchy Eyes	❑ Earaches	❑ Tongue Sores
❑ Poor Vision	❑ Color Blindness	❑ Ear Ringing	❑ Grinding Teeth
❑ Blurry Vision	❑ Excessive Tearing	❑ Excess Ear Wax	❑ Lock Jaw/ Clicks

Temperature & Thirst

❑ Cold Hands & Feet	❑ Excessive Thirst	❑ Hot Hands	❑ Hot in Afternoon
❑ Cold "in the bones"	❑ Thirst for Hot Drinks	❑ Hot Feet	❑ Hot at night
❑ Chills	❑ Thirst, No desire to Drink	❑ Hot Chest	❑ Night Sweats
❑ Thirst for Cold Drinks	❑ Absence of Thirst	❑ Hot Flashes	❑ Unusual Sweats
			❑Other:_____

Male Reproductive Health

❑ Decreased Libido	❑ Nocturnal Emission	❑ Prostate Disease
❑ Excess Libido	❑ Testicular Pain	❑ Vasectomy
❑ Premature Ejaculation	❑ Genital Pain	❑ Hernia
❑ Rashes/ Itching	❑ Herpes	❑ Genital Sores
❑ Jock Itch	❑ Impotence	❑ Other:_____

Infection Screening

Have you ever tested Positive? Please indicate when

❑ HIV_____	❑ Mono/ Epstein Bar _____	❑ Gonorrhea _____
❑ Tuberculosis_____	❑ Hepatitis _____	❑ Syphilis _____
❑ Lymes Disease _____	❑ Herpes (oral/ genital)_____	❑ Other:_____

Gynecology

First Day of Last Menses:_____ At what age did you start menstruating?_____

Length of your cycle? (ex 28-30 days):_____ Duration of Bleeding:_____ Are you Currently Pregnant? Y / N

How would you describe your flow? ❑ Light ❑ Medium ❑ Heavy ❑ Irregular ❑ Other:_____

What Color is the Blood? ❑ Bright Red ❑ Dark Red ❑ Pale Red ❑ Purplish ❑ Brownish

Are there clots? Y / N ❑ Dime Size ❑ Quarter Size

Form of Birth control:_____How long with this method?_____

Number of Pregnancies? _____ Deliveries:_____ Cesareans:_____Abortions:_____ Miscarriages:_____

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Please list any symptoms you have before/ during or after your period:_____

_____

❑ Irregular Periods	❑ Pain with Intercourse	❑ Vaginal Dryness
❑ Painful Periods	❑ Post Coital Bleeding	❑ Vaginal Discharge
❑ PMS	❑ Fibroids	❑ Vaginal Soreness
❑ Menopausal Syndrome	❑ Endometriosis	❑ Spotting Between Periods
❑ Abnormal Pap Smear	❑ Infertility	❑ Breast lumps
❑ Polycystic Ovarian Syndrome (PCOS)	❑ Pain at Ovulation	❑ Nipple discharge
❑ Pelvic Inflammatory Disease (PID)	❑ Genital Sores	❑ Other:_____