Piedmont Acupuncture & Wellness Clinic

Patient Information

Name:			
First	Middle	Last	
Address:			
Street	City	State	Zip
Phone:		Email:	
Age:	DOB:	Marital Status:	
Occupation:		Employer:	
Emergency Contact:			
Name	Phone#	Relationship	

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

Referred By:	
Name	Phone#
Have you had acupuncture before? Y / N	Date:

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Health History

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.____

Level of impairment: 1 I------I------I------I------I------I------I------I------I------I 10   For how long:________________________

What makes it better:____

What makes it worse:____

2.____

Level of impairment: 1 I------I------I------I------I------I------I------I------I------I 10   For how long:________________________

What makes it better:____

What makes it worse:____

3.____

Level of impairment: 1 I------I------I------I------I------I------I------I------I------I 10   For how long:________________________

What makes it better:____

What makes it worse:____

4.____

Level of impairment: 1 I------I------I------I------I------I------I------I------I------I 10   For how long:________________________

What makes it better:____

What makes it worse:____

Please provide any additional information below

____

____

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Please list any diagnoses you may have been given

____

____

Please list any Medications you are currently taking (Include dosage and frequency)

____

____

Please list any Vitamins or Supplements you are currently taking

____

____

Please list any Food or Drug allergies and reactions you have

____

____

Do you have any Diet Restrictions? If so please describe

____

____

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

____

____

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

____

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

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

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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Cardiovascular

❑ 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	❑ Anemia ❑ Phlebitis ❑ High Blood Pressure ❑ Low Blood Pressure ❑Other:__________________

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
- ❑ Gas
- ❑ Feel a "lump" in the throat
- ❑ Heartburn/Reflux
- ❑ Belching
- ❑ Bad Breath
- ❑ Excessive Saliva
- ❑ Poor Appetite
- ❑ Excessive Hunger
- ❑ Hunger but No Desire to Eat
- ❑ Hemorrhoids
- ❑ Bowel Incontinence
- ❑ Ulcer
- ❑ 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

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Head, Eyes, Ears, Nose, Throat

❑ 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
❑ Erectile Dysfunction	❑ Herpes	❑ Genital Sores
❑ Rashes/ Itching		❑ Other:________________________
❑ Jock Itch		

Infection Screening

Have you ever tested Positive? Please indicate when

❑ HIV___________________________	❑ Mono/ Epstein Bar ______________	❑ Gonorrhea _____________________
❑ Tuberculosis___________________	❑ Hepatitis ______________________	❑ Syphilis _______________________
❑ Lymes Disease _________________	❑ Herpes (oral/ genital)____________	❑ Other:_________________________

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

Signature:______________________________________**Date:**_____________________________________

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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:_________

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

____

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

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

Signature:___________________________________**Date:**__________________________________