AcuYogaWellness

acupuncture, yoga & herbal medicine

- New Patient Demographic Information -

Name (Last, First, Middle):			Todays' Date:
Street Address:	City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:	
Email:		Referral?:	
Emergency Contact:	Emergency Contact Phone:	Primary Care Physician (name and number):	
Sex: ❑ Male ❑ Female	Date of Birth:	Age:	Martial Status:
Social Security Number:		Employed: ❑ F/T ❑ P/T	Student: ❑ F/T ❑ P/T ❑ N.A.
Patient Employer:		Occupation:	
Employer Address:			

** Please fill out the rest of this page IF you are using insurance **

- Patient Insurance Information -

(Patient: Please present your Insurance Card and Photo ID for Copying)

Insurance Company (Name):		Date of Birth:	
Insurance Company (Street Address):	City:	State:	Zip Code:
Phone Number (Insurance Company):	Name of Policy Holder:		
Insurance ID#:	Group ID#:	Group Name:	

- Guarantor/Parent/Responsible Party Information -

Guarantor's Name (Last, First, Middle):		Guarantor's Date of Birth:		
Relationship to Patient:		Guarantor's SSN#:		
Guarantor's Street Address:		City:	State:	Zip Code:
Guarantor's Home Phone:	Guarantor's Alt. Phone:	Guarantor's Email:		

Have you ever had Acupuncture before?: ☐ Yes ☐ No

Chief Complaint (*primary reason for this visit)*: _____

Medical Diagnosis (*if any)*: _____ How long have you had this condition? _____

Is it getting worse?: ☐ Yes ☐ No / What seemed to be the initial cause?: _____

_____

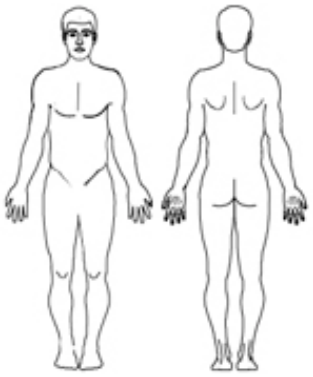
What seems to make it better?: _____

What seems to make it worse?: _____

Does this condition interfere with your: ☐ Sleep ☐ Work ☐ Other: _____

Please indicate the location and type of pain *(if applicable)*:

Ache	Numbness	Pins + Needles	Burning	Stabbing
XX	===	.....	+++	/////



Have you received other types of treatment for your complaint?: ☐ Yes ☐ No

If yes, what was it? _____ / Did it help?: ☐ Yes ☐ No

Do you have any specific questions or concerns that you would like me to address?:

_____

_____

_____

Height: _____ Weight: _____ lbs

Do you have a pacemaker? ☐ Yes ☐ No / Are you pregnant? ☐ Yes ☐ No

Are you taking any blood thinners *(Coumadin/Warfarin, Heparin, Plavix)*? ☐ Yes ☐ No

Allergies (list allergies or sensitivities to any types of medicine or substances): _____

Prescription Medications *(you may also attach a separate sheet)*:_____

_____

Vitamins/Supplements/Herbs: _____

Hospitalizations/Surgeries (specify date & reason): _____

- Medical History -

Please indicate if *you* have had any of the following:

☐ AIDS/HIV	☐ Diabetes	☐ High Blood Pressure	☐ Mental Disorder	☐ Seizures
☐ Alcoholism	☐ Epilepsy	☐ High Fevers	☐ Migraines	☐ Stroke
☐ Allergies	☐ Eating Disorder	☐ IBS	☐ Multiple Sclerosis/M.S.	☐ Ulcers
☐ Asthma	☐ Glaucoma	☐ Jaundice	☐ Mumps	☐ Vascular Disease
☐ Cancer	☐ Heart Disease	☐ Kidney Disease	☐ Obesity	☐ Venereal Disease/STDs
☐ Colitis	☐ Hepatitis	☐ Meningitis	☐ Pneumonia	

- Family Health History -

Please indicate if a *blood relative* has had any of the following:

☐ Alcoholism	☐ Cancer	☐ Heart Disease	☐ High Blood Pressure
☐ Allergies	☐ Diabetes	☐ Seizures	☐ _____
☐ Asthma	☐ Heart Disease	☐ Stroke	☐ _____

- Social History + Lifestyle -

☐ Alcohol	☐ Marijuana	☐ Stress	☐ Physical Abuse	☐ Exercise
☐ Tobacco	☐ Recreational Drugs	☐ Occupational Hazards	☐ Emotional Abuse	Type: _____
				_____
				Freq.: _____

- Review of Systems -

General

- ☐ Fever
- ☐ Fatigue
- ☐ Low energy
- ☐ Excessive energy
- ☐ Often feel warm
- ☐ Often feel cold/cool
- ☐ Spontaneous Sweating
- ☐ Lack of Sweating
- ☐ Trouble Falling Asleep
- ☐ Trouble Staying Asleep
- ☐ Vivid Dreams

Skin/Hair

- ☐ Rashes
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Pimples
- ☐ Ulcerations/Sores
- ☐ Dry Skin
- ☐ Itching
- ☐ Hives
- ☐ Redness
- ☐ Dandruff
- ☐ Hair Loss
- ☐ Fungal Infections
- ☐ Bruise Easily

Head/Eyes/Ears/Nose/Throat

- ☐ Eye Pain
- ☐ Eye Strain
- ☐ Red Eyes
- ☐ Itchy Eyes
- ☐ Floaters
- ☐ Poor Vision
- ☐ Blurred Vision
- ☐ Watery Eyes
- ☐ Night Blindness
- ☐ Sensitive Teeth
- ☐ Teeth Grinding
- ☐ TMJ
- ☐ Bleeding Gums
- ☐ Toothache
- ☐ Dry Throat/Mouth
- ☐ Itchy/Sore Throat
- ☐ Feeling of "lump" in throat
- ☐ Mouth/Tongue Ulcers
- ☐ Difficulty Swallowing
- ☐ Copious Saliva
- ☐ Dry/Cracked Lips
- ☐ Tinnitis/Ringing in Ears
- ☐ Ear Discharge
- ☐ Vertigo
- ☐ Chronic Ear Infections
- ☐ Hearing Loss
- ☐ Frequent Colds
- ☐ Chronic Sinus Infections
- ☐ Frequent Colds
- ☐ Runny Nose
- ☐ Nosebleeds
- ☐ Chronic Cough
- ☐ Nasal Congestion
- ☐ Sneezing
- ☐ Phlegm
- ☐ Shortness of Breath
- ☐ Wheezing/Asthma
- ☐ Hay Fever/Allergies
- ☐ Headache
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Fainting
- ☐ Migraines

Cardiovascular

- ☐ Palpitations
- ☐ Varicose Veins
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Chest Pain/Angina
- ☐ Poor Circulation
- ☐ Colds Hands/Feet
- ☐ Swelling

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Stool w/Foul Odor
- ☐ Gas
- ☐ Bloating
- ☐ Hiccups
- ☐ Bad Breath/Halitosis
- ☐ Black-colored Stool
- ☐ Burning/Itchy Anus
- ☐ Heartburn
- ☐ Rectal Pain
- ☐ Hemorrhoids
- ☐ Mucus in Stool
- ☐ Intestinal Pain
- ☐ IBS
- ☐ Borborygmus (gurling sounds in abdomen)
- ☐ Ravenous Appetite
- ☐ Poor Appetite
- ☐ Cravings: _____ _____

Bowel Movements:
Freq.: _____

Quality:
- ☐ Well-Formed
- ☐ Loose
- ☐ Watery/Diarrhea
- ☐ Dry/Hard to Pass

Genitourinary

- ☐ Bedwetting
- ☐ Incontinence
- ☐ Kidney Stones
- ☐ Discharge
- ☐ Urgent/Freq. Urination
- ☐ Scanty Urination
- ☐ Excessive Urination
- ☐ Burning/Painful Urination
- ☐ Incomplete Urination
- ☐ Wake up to Urinate
- ☐ Blood in Urine
- ☐ Cloudy Urine
- ☐ Impotence
- ☐ ↑ libido
- ☐ ↓ libido
- ☐ Itching of Genitals
- ☐ Genital Lesions/Warts
- ☐ Venereal Disease/STD

Neurological

- ☐ Paralysis
- ☐ Tremors
- ☐ Loss of Balance
- ☐ Loss of Coordination
- ☐ Numbness/Tingling
- ☐ Epilepsy/Seizures
- ☐ Tics
- ☐ Chronic Fatigue
- ☐ _____

Psychological

- ☐ Worry
- ☐ Grief
- ☐ Anxiety
- ☐ Insecurity
- ☐ Depression/Sadness
- ☐ Anger
- ☐ Frustration
- ☐ Impatience
- ☐ Stress
- ☐ Forgetfulness
- ☐ Lack of Will Power
- ☐ Fear/Fright
- ☐ Nervousness
- ☐ Irritability
- ☐ Lack of Support

Musculoskeletal

- ☐ Joint Pain
- ☐ Fibromyalgia
- ☐ Muscle Spasm
- ☐ Sore Muscles
- ☐ Body Aches/Stiffness
- ☐ Heavy Limbs
- ☐ Limited Range of Motion
- ☐ Muscle Weakness
- ☐ Joint Swelling
- ☐ Pinched Nerve
- ☐ Difficulty Walking
- ☐ Arthritis
- ☐ Neck/Shoulder Pain
- ☐ Upper/Mid Back Pain
- ☐ Low Back Pain
- ☐ Arm/Leg/Hand/Foot Pain
- ☐ Rib Pain
- ☐ _____
- ☐ _____

Gynecology

☐ PMS	☐ Heavy Flow	☐ Painful Periods	☐ Vaginal Discharge	☐ Use of Birth Control Pills
☐ Clots	☐ Scanty Flow	☐ Irregular Periods	☐ Vaginal Sores	☐ _____
☐ Spotting (mid cycle)	☐ Fibroids (breast + uterine)	☐ Yeast Infections	☐ Vaginal Odor	☐ _____

Age of Menarche (first menses): _____
Days of Menstrual Flow: _____
Length of Cycle (day 1 to day 1): _____
Date Last Period Began: _____

Age of Menopause: _____
Symptoms: _____
Are you currently on Hormone Replacement Therapy (HRT)? ☐ Yes ☐ No
If yes, how long?: _____

# of Pregnancies: _____
# of Live Births: _____
# of Miscarriages: _____
# of Abortions: _____

Clinical Notes (for practitioner use only)

Onset (gradual or acute):

Location:

Duration:

Character:

Associated Symptoms:

Aggravating Factors:

Relieving Factors:

Temporal (setting):

Severity:

Blood Pressure: _____ /_____ mmHg ☐ Left ☐ Right

Respiration Rate:

Pulse Rate:

Pulse:
- Left:
- Right:

Tongue:
- Body:
- Coating: