ACUPUNCTURE
WELLNESS CENTER

PATIENT INFORMATION

Date: _________________

Name: ____

Address: ____

City: _______________________ State: __________ Zip Code: ______________

Phone numbers: Home ____________ Work_____________ Cell _______________

Sex: Male _____ Female _____ Age: _____ Date of Birth: _________________

In case of emergency who should be notified? ______________________________

Relationship with patient: _______________ Phone: ________________________

Primary Physician: ____________________ Phone: ________________________

CHIEF COMPLAINT

What is the condition for which you are seeking treatment:

____
____
____

Rate the severity of your condition (circle one):

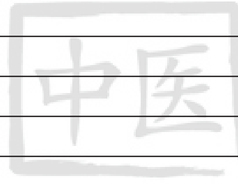
0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Mild Moderate Severe

Other health concerns:

____
____

Please leave lines blank - OFFICE USE ONLY - answer questions below



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1. How would you describe your general mood? ☐ Normal ☐ Depressed ☐ Other ☐ Anxious ☐ Irritable ______

2. Has your appetite ☐ increased ☐ decreased ☐ same

3. How is your digestion? ☐ Normal ☐ Bloating ☐ Tired after meals ☐ Other ☐ Reflux ☐ Full easily ☐ Lots of gas ______

4. Do you have a daily bowel movement? Yes / No
   ☐ Tendency toward constipation
   ☐ Tendency toward loose stools
   ☐ IBS

5. Do you have any issues with regard to urination? Yes / No ☐ Frequent ☐ Several times at night ☐ Urgency ☐ Other ☐ Incontinence ______

6. Generally speaking are you ☐ hot easily ☐ cold easily ☐ neither

7. Do you perspire easily (with very little exertion)? Yes / No Any night sweats? Yes / No

8. Are you thirsty easily? Yes / No Preference for: ☐ Room temp. ☐ Cold ☐ Warm liquids?

9. How is your sleep?
   ☐ Generally sound sleep & at least 6 - 8 hours per night
   ☐ Trouble falling asleep, but sleep well thereafter
   ☐ Toss and turn most of the night ☐ Wake early and can't go back to sleep

10. How is your energy level? ☐ Very good ☐ Always tired ☐ Typically ok, but could be better ☐ Other ______ ☐ Tired easily ______

Female patients:
Is your cycle regular? Yes / No ☐ Normal Flow ☐ Heavy Flow ☐ Scanty ☐ Clots
Do you have PMS? ☐ Cramping ☐ Emotional ☐ Other ______
Are you taking birth control? Yes / No
Menopausal? Yes / No Postmenopausal? Yes / No Children? Yes / No

Medications:
☐ None ☐ Pain ☐ Cholesterol ☐ Heart
☐ Anxiety ☐ Muscle Spasms ☐ Thyroid ☐ Other ______
☐ Depression ☐ Blood pressure ☐ Hormone (HRT) ☐ Other ______

Other
Any significant traumas? Yes / No ______
Any major surgeries? Yes / No ______
Allergies ______ ☐ Headaches ☐ Ringing in the ears ☐ Visual Floaters