Body and Soul Acupuncture

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Patient Information

Date_____

Name _____

Address_____

City State Zip _____

Age _____ Birth date _____

Occupation _____

Company Name _____

Primary Physician _____

Physician Phone Number _____

How did you hear about us? _____

Contact Information

Home Phone _____

Work Phone _____

Other/Cell Phone _____

Email _____

Would you like to receive our monthly newsletter? ☐Yes ☐No

Another person we may contact if needed:

Name _____

Relationship _____

Home Phone _____

Work Phone _____

Primary Concerns

What are the concerns for which you are seeking care? (symptoms and date of onset)

1. _____

2. _____

3. _____

Has this condition been diagnosed by a physician or other provider? ☐ Yes ☐ No

If yes, diagnoses: _____

Are you being treated for this condition by anyone else? ☐ Yes ☐ No

If yes, what is the treatment? _____

Have these treatments helped? ☐ Yes ☐ Somewhat ☐ Not Much ☐ Not At All

How long have you had this condition? _____

What makes your condition better? (movement, rest, heat, cold, sleeping, etc)

_____

What makes your condition worse? (fatigue, stress, certain foods or times of day, heat, cold, hunger, etc)

_____

Significant trauma/injuries, hospitalizations, etc. Please include the date.

_____

_____

_____

Are you hypersensitive or allergic to any foods, drugs, chemicals, or environmental substances?

_____

_____

Please list medications, herbal supplements, and vitamins you are currently taking:

Drug/Supplement/Vitamin	Reason for Taking	For How Long	Dosage	Frequency

Personal Health History

Are you taking Coumadin or Warfarin? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No Do you have seizures? ☐ Yes ☐ No

How long has it been since you have had a complete medical exam? _____

Have you ever been diagnosed with any of the following:

☐ Diabetes
☐ Arthritis
☐ Depression
☐ AIDS / HIV
☐ Cancer
☐ High Blood Pressure
☐ Heart attack
☐ Anemia
☐ Asthma
☐ Hyper / hypo Thyroid
☐ Stroke

Check symptoms that you have or have had in the last year:

Eyes / Ears / Nose / Throat

☐ Dry, red, itchy eyes
☐ Blurred vision
☐ Floating spots in vision
☐ Ringing in ears
☐ Loss of hearing
☐ Earache
☐ Sinus congestion / infection
☐ Frequent runny nose
☐ Frequent colds
☐ Nose bleeds
☐ Frequent sore throat
☐ Teeth grinding
☐ Canker sores
☐ Weak, hoarse voice
☐ Goiter / difficulty swallowing

Cardiovascular & respiratory

☐ Shortness of breath
☐ Persistent cough
☐ Seasonal allergies
☐ Chest tightness
☐ Irregular heartbeat
☐ Palpitations
☐ Swelling of hands or feet

Head

☐ Headaches Frequency_____
☐ Migraines Duration _____
Location _____ Pain Quality _____
(sharp, dull, stabbing)
☐ Dizziness / vertigo
☐ Tremors Where _____
☐ Jaw pain
☐ Loss of balance
☐ Trigeminal neuralgia

Temp / Sweating

☐ Tend to feel hot
☐ Tend to feel cold
☐ Hot flashes
☐ Sweat with little exertion
☐ Night sweats
☐ Cold hands / feet

Skin

☐ Itching / rashes
☐ Eczema or psoriasis
☐ Acne
☐ Dry skin
☐ Hair loss
☐ Bruises easily
☐ Slow healing wounds
☐ Weak or ridged nails

Gastrointestinal

☐ Belching, gas, bloating
☐ Gall bladder trouble
☐ Hemorrhoids
☐ Poor appetite
☐ IBS
☐ Constipation
☐ Diarrhea
☐ Abdominal pain / cramps
☐ Nausea / indigestion
☐ Vomiting
☐ Excessive hunger
☐ Bad breath
☐ Strong smelling stools
☐ Undigested food in stools
☐ Crohn's disease
☐ Ribside pain
☐ Heartburn / reflux

Musculoskeletal & Extremities

☐ Tremors
☐ Swollen joints
☐ All over body pain
☐ Pain, weakness, numbness, tingling, spasms in:
__ Arms / legs
__ Knees / hips
__ Back / sciatica
__ Feet / hands
__ Neck / upper back / shoulders
__ Heaviness of limbs

Genito / Urinary

☐ Pain / burning when urinating
☐ Frequent urination
☐ Inability to control urine
☐ Leakage of urine (such as when sneezing or laughing)
☐ Kidney infection / stones
☐ Weak urine stream

Emotional

☐ Depression
☐ Difficulty in focusing / concentration
☐ Excessive worry
☐ Anxiety or nervousness
☐ Seasonal depression
☐ Overwhelmed by life
☐ Irritable / angry
☐ Mind racing
☐ Easily stressed

For Men Only

☐ Erection difficulties
☐ Prostate trouble
☐ Hernia

For Women Only

☐ Bleeding between periods
☐ Clots in menses
☐ Excessive menstrual flow
☐ Extreme Menstrual Pain
☐ Irregular cycle
☐ Menopausal symptoms
☐ PMS
☐ Previous miscarriage
☐ Scanty menstrual flow
☐ Could you be pregnant? y n

Lifestyle

How would you rate the following areas in your health in the past month?

Stools ☐ Great ☐ Good ☐ Fair ☐ Poor Comments _____

How many times per day? _____ Do they feel complete? ☐ Yes ☐ No

Stool consistency? ☐ Loose ☐ Formed ☐ Hard to pass ☐ Other_____

What is the color of your stools? _____

Is there blood in your stools? ☐ Yes ☐ No If yes, how often? _____

Urination ☐ Great ☐ Good ☐ Fair ☐ Poor Comments _____

How many times per day? _____ What color is your urine? _____

After you've gone to sleep, do you get up to urinate? ☐ Yes ☐ No If yes, how often? _____

Is your urination painful? ☐ Yes ☐ No

Diet ☐ Great ☐ Good ☐ Fair ☐ Poor Comments _____

How do you feel about the following areas of your life in the past month?

Energy ☐ Great ☐ Good ☐ Fair ☐ Poor Comments _____

On a scale of 1 to 10? (10 is high energy) _____

Exercise ☐ Great ☐ Good ☐ Fair ☐ Poor Comments _____

How often? _____ What kind? _____

Sleep ☐ Great ☐ Good ☐ Fair ☐ Poor Comments _____

How many hours per night do you normally sleep? _____

You have difficulties with: ☐ Falling asleep ☐ Staying asleep ☐ Dream-disturbed sleep
☐ Waking up at around _____ am/pm and not being able to fall back asleep

Emotions Stress level: ☐ Low ☐ Medium ☐ High

Are you currently working with a counselor? ☐ Yes ☐ No

If possible, please describe the most challenging emotion(s) you experience: _____

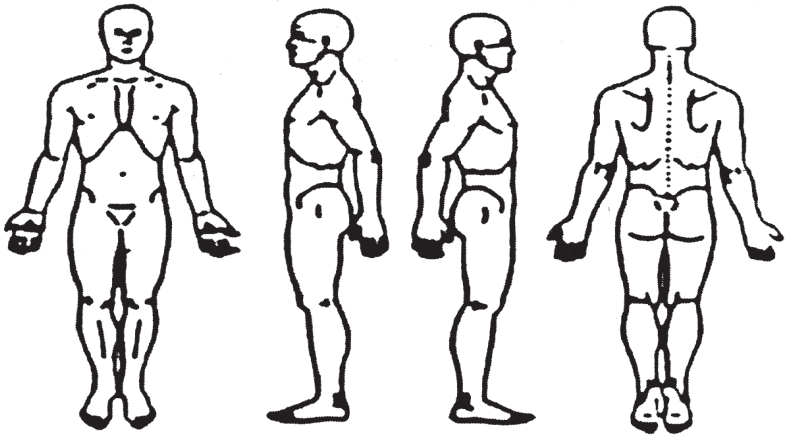
_____

When do you most often feel this emotion? _____

What goals do you have for your sessions? _____

Pain

Please answer the following questions if you have pain.



Indicate on the diagram your areas of pain.

How long have you had this pain? _____

_____

Describe the onset of your pain: _____

_____

_____

_____

_____

_____

_____

_____

_____

On a scale of 1 to 10 (10 being the worst), how strong is your pain? _____

What does the pain feel like? (check all that apply)

☐ Dull ☐ Sharp ☐ Stabbing ☐ Sore ☐ Achy ☐ Cramping ☐ Burning

☐ Constant ☐ Comes and Goes ☐ Fixed ☐ Moves About

Does the pain radiate? ☐ Yes ☐ No

If so, where? _____

Does anything relieve this pain? (i.e. medications, over-the-counter drugs, liniments) _____

_____

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

X Patient's Signature _____ Date _____