WELLNESS TO BE
Acupuncture | Eastern Medicine | Nutrition

New Patient Form

First Name:	**Last Name:**		**Male/Female**
Address:			
City:		State:	Zip:
Phone:		Marital Status:	
Email:		Drivers License #:	
Date of birth:	Age:	Soc. Sec #:	
Emergency contact:		Relationship:	Phone:
Referred by:			

Please describe the main reason for your visit today:

_____

_____

_____

Have you ever had acupuncture before? _____ Yes _____ No

If yes, by whom? _____

Have you ever received any treatment for the above condition? _____ Yes _____ No

If yes, where? _____

When? _____

By Whom? _____

What was the diagnosis? _____

What kind of treatment (s)? _____

Was the result satisfactory? _____

List any medications you are taking

Medication	Strength	How many/day	For how long

Please list substances your are allergic to: _____

_____

Health Habits: (tobacco, alcohol, illicit drugs, special diet, exercise, exposure to toxins)

Habit	How much or often (day/week)	How Long

Please indicate if you have any of the following:

- ❑ Cardiac pacemaker
- ❑ Seizure disorder
- ❑ Bleeding disorder/ Blood thinners
- ❑ Fainting disorders
- ❑ High blood pressure
- ❑ Believe you are or may be pregnant
- ❑ HIV/AIDS positive
- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ Other:_____

List all major childhood and adult illnesses:

_____

_____

Have you had any surgeries, major accidents or injuries, please explain:

_____

_____

PATIENT HEALTH HISTORY

Please check (✓) symptoms you currently have or have had in the past year.

Name: _____ Date: _____

- ☐ Cold hands/feet
- ☐ Fatigue
- ☐ Feverish in the afternoon or flushes
- ☐ Heat sensation in hands, feet, chest
- ☐ Night sweats
- ☐ Catch colds easily
- ☐ Sweats easily during daytime
- ☐ Dizziness
- ☐ See floating black spots

- ☐ Palpitations
- ☐ Sore on tongue
- ☐ Restlessness
- ☐ Anxiety
- ☐ Chest pain
- ☐ Insomnia

- ☐ Cough (with or without blood)
- ☐ Sinus congestion
- ☐ Dry mouth, throat, nose, or skin
- ☐ Allergies seasonal or food
- ☐ Chills and fever
- ☐ Stiff neck/shoulders
- ☐ Sore throat
- ☐ Difficult breathing

- ☐ Low appetite
- ☐ Loose stools
- ☐ BM sticky or difficult to clean up
- ☐ Constipation or difficult to pass
- ☐ Abdominal bloating or gas after eating
- ☐ Feeling tired after eating
- ☐ Prolapsed organs (previously diagnosed)
- ☐ Bruises easily

- ☐ General feeling of heaviness in body
- ☐ Mental heaviness or fogginess
- ☐ Swollen hands/feet
- ☐ Burning sensation after eating
- ☐ Bad breath
- ☐ Large appetite
- ☐ Mouth, canker or cold sores
- ☐ Bleeding, swollen or painful gums
- ☐ Heartburn/Reflux/Belching
- ☐ Stomach/Abdominal pain
- ☐ Nausea
- ☐ Vomiting (with or without blood)

- ☐ Diarrhea alternating with constipation
- ☐ Tight/suffocating feeling in chest
- ☐ Bitter taste in mouth
- ☐ Blood shoot eyes/dry eyes
- ☐ Anger easily
- ☐ Skin rashes
- ☐ Headache
- ☐ Numbness of hands and feet
- ☐ Muscle spasms, twitching, cramping
- ☐ Seizures/convulsions

- ☐ Sore, cold or weak knees
- ☐ Low back pain
- ☐ Frequent urination
- ☐ Get up more than once a night to urinate
- ☐ Lack of bladder control
- ☐ Memory problems
- ☐ Hair loss
- ☐ Ringing in ears/Tinnitus

Urine is:

☐ Normal color ☐ Clear
☐ Dark yellow ☐ Light Yellow
☐ Cloudy ☐ Scanty
☐ Bad odor ☐ Painful
☐ Burning ☐ Blood or pus
☐ Difficult ☐ Urgent

Libido (sex drive) is:

☐ Normal ☐ Low ☐ High

Women only:

1. Are you pregnant now?
   ☐ Yes ☐ No
2. Number of children:_____
3. Number of pregnancies:_____
4. Miscarriages: _____
5. Abortions:_____
6. Age of first period:_____
7. Age of menopause if applicable:_____
8. Is your menses cycle regular?
   ☐ Yes ☐ No

a. Average number of days in flow:____

b. The flow is:

☐ Normal ☐ Heavy ☐ Light

c. The color is:

☐ red ☐ dark ☐ purple
☐ light brown ☐ brown

d. Do you have the following menstruation related symptoms?

☐ Blood clots
☐ Cramps
☐ Nausea
☐ Breast distension
☐ PMS
☐ Bleeding between periods
☐ Heavy vaginal discharge between periods

e. Birth control:_____

Last PAP/Well Woman Exam:_____

☐ Abnormal PAP Smear
☐ Breast Lump
☐ Sores on genitalis
☐ Uterine Fibroids
☐ Ovarian Cysts

Men Only:

☐ Breast Lump
☐ Genital pain or swelling
☐ Lump in testicles
☐ Ejaculatory problems
☐ Impotence/erectile dysfunction
☐ Penile discharge

General

- ☐ Weight gain
- ☐ Weight loss

Cardio-Respiratory

- ☐ Asthma
- ☐ Shortness of breath
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low Blood Pressure
- ☐ Phlegm Production
- ☐ Persistent Cough
- ☐ Poor circulation
- ☐ Recurrent Bronchitis
- ☐ Swelling of Ankles
- ☐ Varicose Veins

Gastrointestinal

- ☐ Black stools
- ☐ Blood in stools
- ☐ Difficulty swallowing
- ☐ Gas/Flatulence
- ☐ Hemorrhoids
- ☐ Indigestion

Eye, Ear, Nose, Mouth, Throat

- ☐ Glasses
- ☐ Hay fever
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Loss of voice
- ☐ Olfactory problems
- ☐ Recurrent sore throat
- ☐ Sinus problems
- ☐ Taste changes
- ☐ Vision of halos

Musculoskeletal

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Double vision
- ☐ Hands
- ☐ Hips
- ☐ Joints
- ☐ Legs
- ☐ Muscle
- ☐ Neck shoulders

PAIN SCALE

Severe Pain: 10/10 No Pain: 0/10

For each pain area use a fraction scale for intensity:

Example: Slight pain = 2 – 3/10
Moderate pain = 5 – 7/10

PAIN EVALUATION

Using the following symbols mark the areas of pain.

///	XXX	OOO	###
Stabbing	Burning	Pins/Needles	Numbness