

Piedmont Acupuncture & Wellness Clinic

Patient Information

Name:			
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#

Piedmont Acupuncture & Wellness Clinic

Health History

Patient Name _____

Date _____

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: $\overset{1}{\text{I-----}}$ $\overset{5}{\text{I-----}}$ $\overset{10}{\text{I-----}}$ For how long: _____
What makes it better: _____
What makes it worse: _____

2. _____
Level of impairment: $\overset{1}{\text{I-----}}$ $\overset{5}{\text{I-----}}$ $\overset{10}{\text{I-----}}$ For how long: _____
What makes it better: _____
What makes it worse: _____

3. _____
Level of impairment: $\overset{1}{\text{I-----}}$ $\overset{5}{\text{I-----}}$ $\overset{10}{\text{I-----}}$ For how long: _____
What makes it better: _____
What makes it worse: _____

4. _____
Level of impairment: $\overset{1}{\text{I-----}}$ $\overset{5}{\text{I-----}}$ $\overset{10}{\text{I-----}}$ For how long: _____
What makes it better: _____
What makes it worse: _____

Please provide any additional information below:

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Cardiovascular

<input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Slow Heart Rate <input type="checkbox"/> Fast Heart Rate <input type="checkbox"/> Palpitations	<input type="checkbox"/> Irregular Heart Beats <input type="checkbox"/> Palpitations <input type="checkbox"/> Varicose/Spider Veins <input type="checkbox"/> Blood Clots	<input type="checkbox"/> Hand/Feet Swelling <input type="checkbox"/> Fainting <input type="checkbox"/> Bleed/Bruise Easily <input type="checkbox"/> Chest Pain/Pressure	<input type="checkbox"/> Anemia <input type="checkbox"/> Phlebitis <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Other: _____
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Respiratory

<input type="checkbox"/> Pain with Breathing <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Shallow Breathing <input type="checkbox"/> Wheezing	<input type="checkbox"/> Production of Phlegm <input type="checkbox"/> Recurrent/ Chronic Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Chest Tightness	<input type="checkbox"/> Frequent Colds <input type="checkbox"/> Frequent Fevers <input type="checkbox"/> Cough Blood	<input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Pneumonia <input type="checkbox"/> Asthma
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Gastro-Intestinal

Bowel Movement: How often? _____ x/ _____ day(s)

<input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea/Vomit <input type="checkbox"/> Bloating <input type="checkbox"/> Gas <input type="checkbox"/> Feel a "lump" in the throat <input type="checkbox"/> Heartburn/Reflux <input type="checkbox"/> Belching <input type="checkbox"/> Bad Breath <input type="checkbox"/> Excessive Saliva <input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Excessive Hunger <input type="checkbox"/> Hunger but No Desire to Eat <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Bowel Incontinence <input type="checkbox"/> Ulcer <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> IBS/Crohns Disease <input type="checkbox"/> Blood in Stool <input type="checkbox"/> Rectal Pain <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Stomachaches	<input type="checkbox"/> Tired after BM <input type="checkbox"/> BM Difficult to Pass <input type="checkbox"/> Cramps w/ BM <input type="checkbox"/> Incomplete BM <input type="checkbox"/> Alternate Constipation/ Loose Stool <input type="checkbox"/> Loose Stool <input type="checkbox"/> Diarrhea <input type="checkbox"/> Dry Stool <input type="checkbox"/> Constipation <input type="checkbox"/> Excessive Weight Gain <input type="checkbox"/> Excessive Weight Loss
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Genito-Urinary

<input type="checkbox"/> Dark Urine <input type="checkbox"/> Clear Urine <input type="checkbox"/> Cloudy Urine <input type="checkbox"/> Burning Urine	<input type="checkbox"/> Scanty Urine <input type="checkbox"/> Profuse Urine <input type="checkbox"/> Frequent Urine <input type="checkbox"/> Urgent Urine	<input type="checkbox"/> Blood in Urine <input type="checkbox"/> Painful Urination <input type="checkbox"/> Nocturnal Urination <input type="checkbox"/> Difficult Start/Stop	<input type="checkbox"/> Frequent UTI <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Incontinence
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Hair, Skin, Nails

<input type="checkbox"/> Rashes <input type="checkbox"/> Acne <input type="checkbox"/> Dandruff <input type="checkbox"/> Itching <input type="checkbox"/> Warts	<input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Dermatitis <input type="checkbox"/> Face Flushing <input type="checkbox"/> Hives	<input type="checkbox"/> Thick Skin <input type="checkbox"/> Scaly Skin <input type="checkbox"/> Thin Skin <input type="checkbox"/> Dry Skin <input type="checkbox"/> Dry Nails	<input type="checkbox"/> Dark Under-eyes <input type="checkbox"/> Abscesses/Infections <input type="checkbox"/> Hair Loss <input type="checkbox"/> Dry/Brittle Hair <input type="checkbox"/> Premature Greying	<input type="checkbox"/> Weak Nails <input type="checkbox"/> Ridged Nails <input type="checkbox"/> Change in Hair/Skin Texture <input type="checkbox"/> Other _____ _____
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Dry I----I----I----I----I----I----I----I----I----I Oily

Piedmont Acupuncture & Wellness Clinic

Head, Eyes, Ears, Nose, Throat

<input type="checkbox"/> Migraines <input type="checkbox"/> Headaches <input type="checkbox"/> Facial Pain <input type="checkbox"/> Heavy Headed <input type="checkbox"/> Light Headed <input type="checkbox"/> Dizziness <input type="checkbox"/> Poor Vision <input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Night Blindness <input type="checkbox"/> Glasses <input type="checkbox"/> Spots in Eyes <input type="checkbox"/> Eye Strain <input type="checkbox"/> Eye Pain <input type="checkbox"/> Red Itchy Eyes <input type="checkbox"/> Color Blindness <input type="checkbox"/> Excessive Tearing	<input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Poor Smell <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Nasal Discharge <input type="checkbox"/> Poor Hearing <input type="checkbox"/> Earaches <input type="checkbox"/> Ear Ringing <input type="checkbox"/> Excess Ear Wax	<input type="checkbox"/> Dry Lips/Mouth <input type="checkbox"/> Dry Throat <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Sore Throats <input type="checkbox"/> Lip/Mouth Sores <input type="checkbox"/> Tongue Sores <input type="checkbox"/> Grinding Teeth <input type="checkbox"/> Lock Jaw/ Clicks
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Temperature & Thirst

<input type="checkbox"/> Cold Hands & Feet <input type="checkbox"/> Cold "in the bones" <input type="checkbox"/> Chills <input type="checkbox"/> Thirst for Cold Drinks	<input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Thirst for Hot Drinks <input type="checkbox"/> Thirst, No desire to Drink <input type="checkbox"/> Absence of Thirst	<input type="checkbox"/> Hot Hands <input type="checkbox"/> Hot Feet <input type="checkbox"/> Hot Chest <input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Hot in Afternoon <input type="checkbox"/> Hot at night <input type="checkbox"/> Night Sweats <input type="checkbox"/> Unusual Sweats <input type="checkbox"/> Other: _____
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Male Reproductive Health

<input type="checkbox"/> Decreased Libido <input type="checkbox"/> Excess Libido <input type="checkbox"/> Premature Ejaculation <input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> Rashes/ Itching <input type="checkbox"/> Jock Itch	<input type="checkbox"/> Nocturnal Emission <input type="checkbox"/> Testicular Pain <input type="checkbox"/> Genital Pain <input type="checkbox"/> Herpes	<input type="checkbox"/> Prostate Disease <input type="checkbox"/> Vasectomy <input type="checkbox"/> Hernia <input type="checkbox"/> Genital Sores <input type="checkbox"/> Other: _____
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Infection Screening

Have you ever tested Positive? Please indicate when

<input type="checkbox"/> HIV _____ <input type="checkbox"/> Tuberculosis _____ <input type="checkbox"/> Lymes Disease _____	<input type="checkbox"/> Mono/ Epstein Bar _____ <input type="checkbox"/> Hepatitis _____ <input type="checkbox"/> Herpes (oral/ genital) _____	<input type="checkbox"/> Gonorrhea _____ <input type="checkbox"/> Syphilis _____ <input type="checkbox"/> Other: _____
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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: _____

- | | | |
|---|--|---|
| <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Pain with Intercourse | <input type="checkbox"/> Vaginal Dryness |
| <input type="checkbox"/> Painful Periods | <input type="checkbox"/> Post Coital Bleeding | <input type="checkbox"/> Vaginal Discharge |
| <input type="checkbox"/> PMS | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Vaginal Soreness |
| <input type="checkbox"/> Menopausal Syndrome | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Spotting Between Periods |
| <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> Infertility | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS) | <input type="checkbox"/> Pain at Ovulation | <input type="checkbox"/> Nipple discharge |
| <input type="checkbox"/> Pelvic Inflammatory Disease (PID) | <input type="checkbox"/> Genital Sores | <input type="checkbox"/> Other: _____ |

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

Signature: _____ **Date:** _____