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#

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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._____

1 5 10
Level of impairment: I------I------I------I------I------I------I------I------I------I------I For how long:_____

What makes it better:_____

What makes it worse:_____

2._____

1 5 10
Level of impairment: I------I------I------I------I------I------I------I------I------I------I For how long:_____

What makes it better:_____

What makes it worse:_____

3._____

1 5 10
Level of impairment: I------I------I------I------I------I------I------I------I------I------I For how long:_____

What makes it better:_____

What makes it worse:_____

4._____

1 5 10
Level of impairment: I------I------I------I------I------I------I------I------I------I------I For how long:_____

What makes it better:_____

What makes it worse:_____

Please provide any additional information below:

_____

_____

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Patient Name_____ Date_____

Have you had acupuncture before? Y / N Date:_____

Are you taking any anti-coagulant medication? Y / N

Are you pregnant or trying to become pregnant ? Y / N

Please list any diagnoses you may have been given:_____

_____

Please list any Medications you are currently taking (Include dosage and frequency)_____

_____

Please list any Vitamins or Supplements you are currently taking:_____

_____

Please list any Food or Drug allergies and reactions you have:_____

_____

Do you have any Diet Restrictions? If so please describe:_____

_____

Please list any Surgeries & Hospitalizations (type and dates): _____

_____

Please indicate your level of Stress on a scale of 1-10 (1=none, 10=worst ever)

1 5 10
I----------I----------I----------I----------I----------I----------I----------I----------I----------I

How does stress manifest for you (please list any physical/emotional symptoms): _____

_____

What makes your stress worse:_____ _____

What makes your stress better:_____

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Psychological/ Behavioral

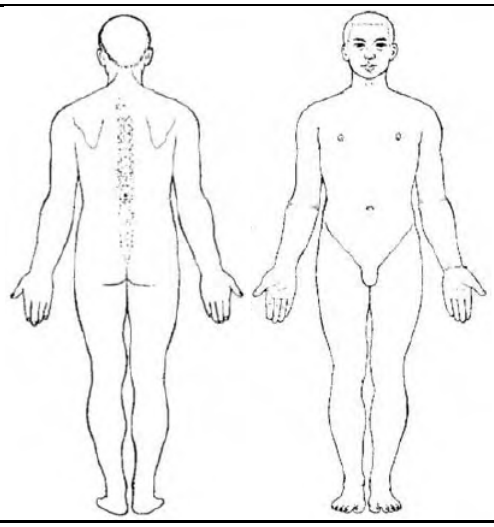
❑ Depression	❑ Aggressive Behavior	❑ Poor Memory/ Forgetful	❑ Easily Stressed
❑ Nervousness	❑ Fearful	❑ ADD/ADHD	❑ Lose Control of Emotions
❑ Anxiety	❑ Grief	❑ Bi-Polar	
❑ Panic Attacks	❑ Indecision	❑ Seasonal Affective Disorder	❑ Other:_____
❑ Irritable	❑ Poor Concentration	❑ Difficulty Expressing Emotions	
❑ Easily Angered	❑ Over Thinking	❑ Frequent Sighing/ Yawning	_____

Musculoskeletal

Please check all that apply:

❑ Pain
❑ Numbness
❑ Tingling
❑ Broken Bones
❑ Sprain/Strain
❑ Joint Swelling
❑ Edema
❑ Carpal Tunnel
❑ Tendonitis
❑ Restricted Movement
❑ Sciatica
❑ Herniated disk
❑ Osteoporosis
❑ Other:_____

❑ Head
❑ Neck
❑ Shoulders
❑ Arms
❑ Elbows
❑ Wrists
❑ Hands/Fingers
❑ Upper Back
❑ Middle Back
❑ Lower Back
❑ Hips
❑ Legs
❑ Knees
❑ Ankles
❑ Feet/Toes



(Please circle areas of concern)

Neurological

❑ Seizures / Epilepsy	❑ Nerve Damage	❑ Significant Lack of Coordination
❑ Tremors	❑ Concussion	❑ Loss of Balance
❑ Paralysis	❑ Peripheral Neuropathy	❑ Vertigo/Dizziness

Sleep

Sleep:_____hrs/ night **Wake**:_____x/night

❑ Difficulty Falling Asleep
❑ Difficulty Staying Asleep
❑ Excessive Sleep
❑ Not Enough Sleep
❑ Sleep Walk/Talk
❑ Disturbing Dreams
❑ Restless Sleep

❑ Not Rested Upon Waking
❑ Wake Too Early
❑ Sleep Apnea
❑ Grind Teeth
❑ Snoring
❑ Night Sweats
❑ Wake to Urinate

Energy

Please indicate on a scale of 1-10 your general level of energy and check all that apply

1 5 10
Low I-----I-----I-----I-----I-----I-----I-----I-----I-----I-----I High

❑ Fatigue
❑ Wired
❑ Energy drop after eating
❑ Energy Drop: Time of Day:_____

❑ Other:_____

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Cardiovascular

❑ Shortness of Breath	❑ Irregular Heart Beats	❑ Hand/Feet Swelling	❑ Anemia
❑ Slow Heart Rate	❑ Palpitations	❑ Fainting	❑ Phlebitis
❑ Fast Heart Rate	❑ Varicose/Spider Veins	❑ Bleed/Bruise Easily	❑ High Blood Pressure
❑ Palpitations	❑ Blood Clots	❑ Chest Pain/Pressure	❑ Low Blood Pressure
			❑Other:_____

Respiratory

❑ Pain with Breathing	❑ Production of Phlegm	❑ Frequent Colds	❑ Bronchitis
❑ Difficulty Breathing	❑ Recurrent/ Chronic Cough	❑ Frequent Fevers	❑ Emphysema
❑ Shallow Breathing	❑ Shortness of Breath	❑ Cough Blood	❑ Pneumonia
❑ Wheezing	❑ Chest Tightness		❑ Asthma

Gastro-Intestinal

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

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

Genito-Urinary

❑ Dark Urine	❑ Scanty Urine	❑ Blood in Urine	❑ Frequent UTI
❑ Clear Urine	❑ Profuse Urine	❑ Painful Urination	❑ Kidney Stones
❑ Cloudy Urine	❑ Frequent Urine	❑ Nocturnal Urination	❑ Incontinence
❑ Burning Urine	❑ Urgent Urine	❑ Difficult Start/Stop	

Hair, Skin, Nails

❑ Rashes	❑ Eczema	❑ Thick Skin	❑ Dark Under-eyes	❑ Weak Nails
❑ Acne	❑ Psoriasis	❑ Scaly Skin	❑ Abscesses/Infections	❑ Ridged Nails
❑ Dandruff	❑ Dermatitis	❑ Thin Skin	❑ Hair Loss	❑ Change in Hair/Skin Texture
❑ Itching	❑ Face Flushing	❑ Dry Skin	❑ Dry/Brittle Hair	❑ Other_____
❑ Warts	❑ Hives	❑ Dry Nails	❑ Premature Greying	_____

Dry I-----I-----I-----I-----I-----I-----I-----I-----I-----I-----I Oily

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Head, Eyes, Ears, Nose, Throat

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

Temperature & Thirst

❑ Cold Hands & Feet	❑ Excessive Thirst	❑ Hot Hands	❑ Hot in Afternoon
❑ Cold "in the bones"	❑ Thirst for Hot Drinks	❑ Hot Feet	❑ Hot at night
❑ Chills	❑ Thirst, No desire to Drink	❑ Hot Chest	❑ Night Sweats
❑ Thirst for Cold Drinks	❑ Absence of Thirst	❑ Hot Flashes	❑ Unusual Sweats
			❑Other:_____

Male Reproductive Health

❑ Decreased Libido	❑ Nocturnal Emission	❑ Prostate Disease
❑ Excess Libido	❑ Testicular Pain	❑ Vasectomy
❑ Premature Ejaculation	❑ Genital Pain	❑ Hernia
❑ Erectile Dysfunction	❑ Herpes	❑ Genital Sores
❑ Rashes/ Itching		❑ Other:_____
❑ Jock Itch		

Infection Screening

Have you ever tested Positive? Please indicate when

❑ HIV_____	❑ Mono/ Epstein Bar _____	❑ Gonorrhea _____
❑ Tuberculosis_____	❑ Hepatitis _____	❑ Syphilis _____
❑ Lymes Disease _____	❑ Herpes (oral/ genital)_____	❑ Other:_____

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:_____

_____

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

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

Signature:_____**Date:**_____