Acupuncture Savvy

Medical Patient Form

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark.

Today's Date: _____

Name:_____

Date of Birth:_____ Age: _____ Gender: M/F

Phone (primary): _____

Address: _____ City: _____

State: _____ Zip: _____

Can we contact you (regarding appointments, information) via email or phone? Yes ____ No _____

If not, how should we correspond with you? _____

Occupation: _____ Employer: _____

In case of an emergency, who can we contact? _____

Relationship and phone: _____

Family physician: _____ Phone: _____

I have read the above information and certify it to be accurate to the best of my knowledge and authorize this office to do what is necessary, in accordance with state statutes, for the care and management of this medical condition.

Patient signature: _____ Date: _____

Acupuncture Savvy provides a newsletter to its patients. By signing this I am authorizing my subscription to this information.

Patient signature: _____ Date: _____

Reason for Today's Visit

Please identify the health concerns you are seeking care for in the order of importance to you. (Symptoms, diagnosis, and date of onset)

1. _____
2. _____
3. _____

What other treatments have you received for these conditions?

_____

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

_____

_____

What makes your condition worse? (stress, certain foods, heat, fatigue, repetitive movements)

_____

_____

Significant Trauma, Hospitalizations, Surgery, X-Rays or Imaging:

Please include accidents, falls, illness along with the month and year:

_____

_____

_____

Allergies:

Are you sensitive or allergic to any foods, drugs, chemical or environmental substances?

_____

_____

Medications and Supplements:

What medications (prescribed and over-the-counter), herbs, vitamins, and supplements are you currently taking? _____

_____

Check each that you currently use:

Laxatives ___	Pain Relievers (NSAIDS) ___	Anti-Depressants ___	Hormones ___
Antibiotics ___	Heart/Blood medication ___	Allergy medication ___	Antacids ___
Sleeping pills ___	Thyroid medication ____	Birth Control Pills or IUD ___	

Exercise and Energy:

How much exercise per week _____ Length of workout _____

Activities _____

How would you describe your energy level? _____ When is it lowest? _____

Highest? _____

Typical Diet:

Breakfast:

_____

Lunch:

_____

Dinner:

_____

Snacks:

_____

Cravings (sweets, carbs, salty, spicy):

_____

Prefer warm or cold drinks

_____

Alcohol and caffeine (amount and frequency per day/week)

_____

Personal History:

Check those that apply to your current (C) or past (P) medical history:

Alcoholism	Allergies	Arthritis	Birth Trauma	Bleeding disorder
Blood disorder	Cancer or tumor	Diabetes	Eating disorder	Heart disease
Hepatitis (liver disease)	High/low blood pressure	Immune disorder	Joint replacement	Kidney disorder/disease
Mental illness	Multiple sclerosis	Ringing of the ear	Seizures/Epilepsy	Sinus infections
STDs	Substance abuse	Thyroid imbalance		

Women Only:

Age you started your period _____ Date of last menstrual cycle _____

# of days from your last period to start of the next _____

Average number days of menstrual flow _____ Are you pregnant? _____

Family History:	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)						
	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____

Please circle any you experience now and under any you have experienced in the past:

Emotional

Mood Swings Nervousness Mental Tension Anxiety

Energy and Immunity

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

Head, Eye, Ear, Nose, and Throat

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts

Tearing/Dryness Impaired Hearing Headaches/Migraines Sinus Problems

Impaired Hearing Ear Ringing Ear Aches Nose Bleeds

Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Blurred Vision

Spots in Vision Double Vision Hay Fever

Respiratory

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis Shortness of Breath

Other Respiratory Problems:

Cardiovascular

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever

Varicose Veins

Gastrointestinal

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas

Heartburn Belching Gall Bladder Disease Liver Disease Hepatitis B or C

Hemorrhoids Abdominal Pain

Genito-Urinary

Kidney Disease Painful Urination Frequent UTI Frequent Urination

Heavy Flow Impaired Urination Blood in Urine Frequent Urination at Night

Kidney Stones

Female Reproductive

Irregular Cycles Breast Lumps/Tenderness Abnormal PAP/Pelvic Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods

Miscarriage(s) Ovarian cysts Endometriosis Uterine fibroids

Polycystic Ovarian Syndrome (PSOS)

Menstrual/Birthing History

Age of First Period: _____ Length of Period: _____ # of Days of Menses: _____

# of Pregnancies: _____ # of Live Births: _____ Date of last cycle: _____

# of Miscarriages: _____

Male Reproductive

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

Neurologic

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

Endocrine

Hypothyroid Hyperthyroid Hypoglycemia Diabetes Mellitus Night Sweats Feeling Hot or Cold

Muscles, Joints and Bones:

Do you have any pain or tightness? _____ Where? _____

Recent Injuries _____

Was this from an auto accident? _____

The pain is (check all that apply):

Sharp____ Dull _____ Numb _____ Deep pain _____ Burning _____ Tingling ____

Shooting ____ Superficial Pain _____ Pain worse/better with heat _____

Pain worse/better with cold _____ Pain worse/better with pressure _____

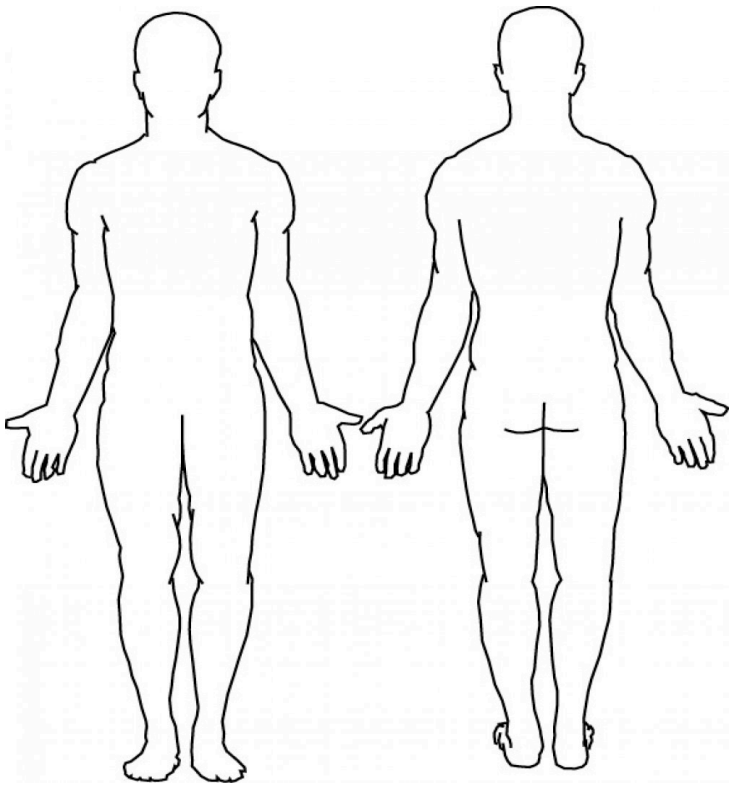
Pain worse in am/pm _____ Pain worse/better with movement ____

I have (check all that apply):

Swollen joints Bone pain Arthritis/joint pain Tendonitis Muscle cramping

Fractured bones Muscle pain Repetitive strain injury Other

Please mark all areas of **pain** the diagram below:



Front Back