Acupuncture One Wellness Center

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Date : _____/_____/_____

Patient Name _____ Age ___ Male / Female _____

Date of Birth _____/_____/_____ Marital Status _____

Referred By _____

Email_____

Phone (H) (_____) _____ - _____ Phone (Cell) (_____) _____ - _____

Address_____

City _____ State_____ Zip _____

Driver's License No._____

Emergency Information (*Please indicate who to notify in case of emergency)*

Name _____ _____

Relationship _____

Phone(H)(_____)_____-_____Phone(W)(_____)_____-_____Phone(C)(___)____-_____

Chief Complaint(s) *Please indicate how long you've had the condition(s).*

What kinds of treatments have you received?

List any Hospitalizations & Surgeries (include Date and Place**)**

List medications being taken (include dosage)

Family History (please include the relationship)

Are you allergic to any of the following? If yes, please specify)
[] Medicine [] Food [] Herbs [] Others
Do you have or are you any of the following?
[] Pacemaker [] Electric Implants [] Metal Implants [] Severe Bleeding Disorders
[] Pregnant [] HIV Positive [] Hepatitis A/B/C
Life style:
[] Exercise [] Sedentary [] Eat three meals every day [] Eat at regular time every day
[] Tea [] Coffee [] Soft drink [] Alcohol [] Cigarettes [] Drug

Confidential Patient Health History

Name: _____ Date: ___/___/_____

Please check if you have had (in the past three months):

General

[] Anemia
[] Fatigue
[] Fever
[] Weight Loss
[] Sweats
[] Chills
[] Drug Addiction
[] Poor Appetite
[] Localized Weakness
[] Bleed or Bruise Easily
[] Peculiar Tastes or Smells
[] Strong Thirst (hot or cold drinks)
[] Sudden Energy Drop
[] Poor Sleep Habits
[] Tremors
[] Poor Balance
[] Cravings
[] Weight Gain
[] Alcoholism
[] Tetanus Shot
[] Frequent cold/flu

Skin and Hair

[] Rashes
[] Itching
[] Dandruff
[] Change in hair/skin texture
[] Ulcerations
[] Eczema
[] Open sore
[] Acne
[] Corns
[] Warts
[] Psoriasis
[] Recent moles
[] Loss of Hair
[] Hives
[] Nail Problems
[] Dry skin

Head, Eyes, Ears, Nose and Throat

[] Dizziness/Vertigo
[] Poor Vision
[] Cataracts
[] Ringing in ears
[] Sinus Problems
[] Grinding Teeth
[] Nasal Congestion
[] Headaches
[] Concussions
[] Eye Strain
[] Night Blindness
[] Blurry Vision
[] Poor Hearing
[] Nose Bleeds
[] Hoarseness
[] Migraines
[] Eye Pain
[] Color Blindness
[] Earaches
[] Spots in front of eyes
[] Recurrent Sore Throats
[] Facial Pain

Cardiovascular

[] High Blood Pressure
[] Low Blood Pressure
[] Palpitations
[] Irregular Heartbeat
[] Mitral Stenosis
[] Mitral Prolapse
[] Myocarditis
[] Pneumatic Heart Disease
[] Chest Pain
[] Varicose Veins
[] Swelling of Hands/Feet
[] Fainting
[] Coronary Heart Disease
[] Difficulty in Breathing
[] Hardening of Arteries
[] Phlebitis
[] Blood Clots
[] Cold hands/feet

Respiratory

[] Cough
[] Bronchitis
[] Difficulty breathing lying down
[] Emphysema
[] Coughing Blood
[] Pneumonia
[] Asthma
[] Pain w/ deep breath
[] Production of Phlegm
[] Pleurisy

Gastrointestinal

[] Nausea
[] Vomiting
[] Bad Breath
[] Abdominal Pain or Cramps
[] Indigestion
[] Ulcer
[] Constipation
[] Gas
[] Blood in Stools
[] Rectal Pain
[] Chronic Laxative Use
[] Colitis
[] Diarrhea
[] Belching
[] Black Stools
[] Hemorrhoids
[] Acid Reflux

Genitourinary

[] Bed Wetting
[] Blood in Urine
[] Frequent Urination

[] Kidney Infections / Stones
[] Genital Herpes
[] Cystitis
[] Painful Urination
[] Venereal Disease
[] Incontinence
[] Bladder Infections
[] Prostate Problems

Pregnancy and Gynecology

[] Number of Pregnancies
[] Number of Abortions
[] Number of Births
[] Number of Miscarriages
[] Use of Birth Control
[] Hot Flash/Night Sweats
[] Age at 1st Menstruation
___ Time between Menstruation
___ Duration of Menstruation
___ First Date of Last Menstruation
[] Irregular Periods
[] Frequent changes in emotion
[] Unusual Character (heavy/light)
[] Vaginal Sores
[] Vaginal Discharge
[] Breast Lumps
[] Uterine Fibroids
[] Osteoporosis

Fertility Information

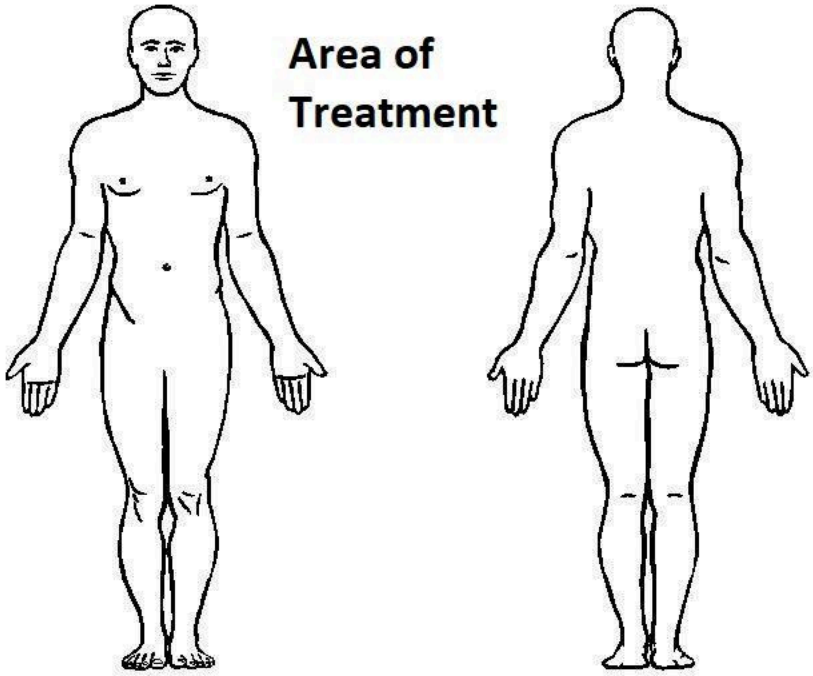
# of IVF procedures_____# of IUI procedures_____

Has a physician diagnosed a difficulty with fertility due to:[] Female Factor?[] Male Factor?[] Unexplained

Musculoskeletal

[] Neck Pain
[] Back Pain
[] Hand/Wrist Pain
[] Muscle Pains
[] Muscle Weakness
[] Shoulder Pain
[] Knee Pain
[] Foot/Ankle Pain
[] Hip Pain

Please indicate on the figures below the areas of the body you experience your pain:
[] dull/achy [] sharp/stabbing [] burning [] tingling [] numbness [] electrical



Neuropsychological

[] Seizures
[] Areas of Numbness
[] Concussion
[] Bad Temper
[] Difficulty Concentrating
[] Dizziness
[] Lack of Coordination
[] Depression
[] Easily susceptible to stress
[] Loss of Balance
[] Poor Memory
[] Anxiety
[] ADD