element
natural healing arts

Acupuncture Patient Information

Name:____ Tel. No. (h): _________________(w):_________________(c):____________________

Email:_____________________________________Address:________________________________ Apt:____ City:__________________________

State: ________________Zip Code:____________________ DOB:___/___/___ Age:_________ Sex: ______ Ht: _________Wt:_______________

Marital Status: ___________________________ No. of Children:___________________

Occupation:____ Employer: ____

Primary Physician: _________________________________Physician Phone: ____

Emergency Contact Name:___________________________________ Phone:___________________________ Relationship to You:____________

How did you hear about us?/Referred by: ____

Would you like to receive emails about specials and classes from Element Natural Healing Arts ? ☐ Yes ☐ No

Insurance Information:

Insurance Company Name:_____________________________ Address:____

Policy No:_________________________ Policy Holder's Name: _____________________________ Policy Holder's Phone:___________________

Policy Holder's Address:___________________________________ City:_____________________ State:______ Zip: _______________________

Policy Holder's DOB: ___/___/___Insurance Company Phone No. for Providers:____

Present History

Main concern you would like me to help you with:____

Other relevant complaints: ____

Is this the result of an accident or injury? ___Yes ___No Explanation of accident ____

When was the first time you were aware of the condition, when and how did it start?____________________________________

____

Have you been given a diagnosis for this condition? If so, what? ____

What kind of treatment(s) have you tried for this condition? ____

What makes it better?____ What makes it worse?____________________________________

Have you had acupuncture before?_________ If so, for what?____

Medical History

Current medicinals/ supplements:____

Previous surgeries: ____

Have you ever been advised to have a surgery that was not done? ____

Have you ever been hospitalized? If so, explain:____

Allergic to any medications? ____Other known allergies? _______________________

Are you currently pregnant? ___Yes ___No (How far along? ______________)Date of last menstrual cycle? ______________________

(Please inform your acupuncturist if at any time you think you may be pregnant.)

Have you ever had or do you currently have:

☐Anemia	☐Arthritis	☐AIDS	☐Cancer	☐Carpal Tunnel
☐Convulsions	☐Diabetes	☐Digestive disorders	☐Epilepsy	☐Epstein-Barr
☐Fibromyalgia	☐German Measels	☐Heart Trouble	☐Hepatitis A/B/C	☐HIV
☐Lupus	☐Multiple Sclerosis	☐Pacemaker	☐Parkinson's Disease	☐PCOS
☐Polio	☐Rheumatic Fever	☐Scarlet Fever	☐Thyroid condition	☐Tuberculosis

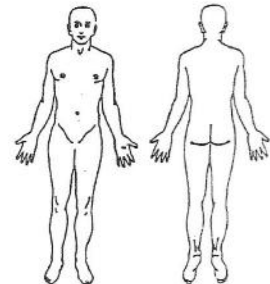
Other: ____

Family History - *Has anyone in your immediate family ever had:*

☐Alcoholism	☐Allergies	☐Arthritis	☐Asthma	☐Cancer
☐Diabetes	☐Drug Problem	☐Epilepsy	☐Glaucoma	☐Heart Trouble
☐High Blood Pressure	☐Kidney Disease	☐Mental Disorder	☐Scoliosis	☐Stroke
☐Tuberculosis	☐Ulcers	Other: ______________________		

If you are experiencing pain, mark the area of your pain with the associated symbols:

++++++ Sharp and Stabbing VVVV Achy
000000 Pins and Needles ///////// Numbness



Patient's Signature: ____

Date: ____

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Patient Information:

Patient Name:_______________________________

Lifestyle

☐Alcohol ☐Tobacco ☐Marijuana ☐Drugs ☐Stress ☐Exercise Type______________ Frequency________
Type______________ Frequency________

General Symptoms

☐Poor appetite ☐Big appetite ☐Recent weight gain/loss ☐Fatigue after eating ☐General fatigue
☐Numbness ☐Lack of strength ☐Body feels heavy ☐Strongly like cold drinks ☐Strongly like hot drinks
☐Poor sleep ☐Heavy sleep ☐Cold hands or feet ☐Poor circulation ☐Shortness of breath
☐Fever ☐Chills ☐Night sweats ☐Sweat easily ☐Muscle cramps
☐Vertigo/ dizziness ☐Bleed, bruise easily ☐Peculiar taste (describe)__________________________

Head, Eyes, Ears, Nose, Throat

☐Headaches ☐Migraines ☐Poor vision ☐Glasses ☐Eye strain
☐Eye pain ☐Red Eyes ☐Itchy eyes ☐Blurred vision ☐Night blindness
☐Glaucoma ☐Cataracts ☐Teeth problems ☐Grinding teeth ☐TMJ
☐Facial pain ☐Gum problems ☐Dry mouth ☐Excessive saliva ☐Sores on lips on tongue
☐Sinus problems ☐Recurrent sore throat ☐Swollen glands ☐Enlarged thyroid ☐Nose bleeds
☐Poor hearing ☐Ear ringing ☐Ear popping ☐Earaches ☐Concussions
☐Loss of smell ☐Change in taste
☐Head or neck problems (explain)____________________________________ ☐Excessive phlegm (color)______________________________

Respiratory

☐Shortness of breath ☐Asthma/wheezing ☐Tight chest ☐Pneumonia ☐Coughing blood
☐Difficulty breathing when lying down ☐Cough recurrent?_________ wet/dry________thick/thin_______phlegm/color___________

Cardiovascular

☐High blood pressure ☐Low blood pressure ☐Chest pain ☐Tachycardia ☐Heart palpitations
☐Blood clots ☐Fainting ☐Difficulty breathing ☐Phlebitis ☐Irregular heartbeat

Gastrointestinal

☐Nausea ☐Vomiting ☐Acid regurgitation ☐Gas ☐Bad breath
☐Hiccup ☐Bloating ☐Diarrhea ☐Constipation ☐Laxative use
☐Black stools ☐Bloody stools ☐Itchy anus ☐Rectal pain ☐Hemorrhoid
☐Anal fissures ☐Mucous in stools ☐Intestinal pain or cramping
Bowel Movements: frequency________________texture/form_________________ color___________________ odor________________________

Musculoskeletal

☐Neck/shoulder pain ☐Joint pain ☐Low back pain ☐Upper back pain ☐Muscle pain
☐Spinal curvature ☐Walking problems ☐Rib pain ☐Muscular Atrophy
☐Other (explain)____

Skin and Hair

☐Rashes ☐Eczema ☐Acne ☐Hives ☐Psoriasis
☐Dandruff ☐Ulcerations ☐Itching ☐Oozing lesions ☐Hair loss
☐Fungal infections ☐Other hair or skin problems____

Neuropsychological

☐Seizures ☐Depression ☐History of abuse ☐Anxiety ☐Considered/attempted suicide
☐Easily stressed ☐Tics ☐Irritability ☐Poor memory ☐Obsessive/compulsive behavior
☐Seeing a therapist ☐Other___________________________________

Genito-urinary

☐Pain with urination ☐Frequent urination ☐Urgent urination ☐Blood in urine ☐Unable to hold urine
☐Incomplete urination ☐Venereal disease ☐Bedwetting ☐Wake to urinate ☐Kidney stone
☐Increased libido ☐Decreased libido ☐Impotence ☐Premature ejaculation ☐Nocturnal emission

Gynecology

Age menses began_______ Date of last period______ Length of cycle__________ Duration of flow_________ Color of blood________________
☐Vaginal discharge (color)____________________ Date of last PAP__________ ☐Irregular periods ☐Painful periods
☐PMS ☐Vaginal odor ☐Vaginal sores ☐Clots ☐Breast Lumps
# of pregnancies_______ # of miscarriages_______ # of abortions_____________ # of premature births______ Onset of menopause (age) ______

Other____