PEACEFUL
ACUPUNCTURE

General Patient Information

Date: _____ Name: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____ Home/Cell Phone: _____

Preferred Method of Contact: ❑ Phone ❑ Text ❑ E-mail

Date of Birth: _____ Age: _____ Place of Birth: _____

Height: _____ Weight: _____ Gender: ❑ Male ❑ Female ❑ Transgender

Marital Status: ❑ Single ❑ Married ❑ Partnered ❑ Divorced ❑ Widowed

Occupation: _____

Guardian (if under 18): _____

Address (if different from patient): _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Current Condition

What is the primary reason for your visit today? _____

_____

How long have you had this condition? _____

Have you experienced this before? _____

What seemed to be the initial cause? _____

Have you seen a physician or other Western medical professional? _____

What therapies have you tried? _____

What other therapies are you currently receiving? _____

_____

Patient History

Please list any known allergies – (ex. Latex, metal, pharmaceuticals, food, environmental):

_____

_____

Prescription drugs you are currently taking:

_____

_____

_____

For what condition and dosage:

_____

_____

_____

Over-the-counter medications you are currently taking:

_____

_____

_____

For what condition and dosage:

_____

_____

_____

Vitamins and herbs you are currently taking:

_____

_____

_____

For what condition and dosage:

_____

_____

_____

If you have ever been hospitalized for any serious medical illness or operation, list the year and procedure:

_____

_____

_____

Physician's Name: _____ Phone Number: _____
Date of last physical examination: _____

Personal Lifestyle Habits (how much/how often)
❑ Cigarettes (packs): _____ ❑ Coffee/Tea (cups): _____ ❑ Alcohol (drinks): _____
Marijuana/Recreational drugs: _____

Specific Diet: _____
What did you eat yesterday?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Exercise: _____ How often: _____

What non-work activities do you enjoy doing? (ex. Reading, TV, meditation, music, etc.) _____
_____

Women – OB/GYN History

Are you pregnant: ❑ Yes ❑ No If yes, how far along: _____

# of pregnancies: _____ # of live births: _____ # of abortions: _____ # of miscarriages: _____

Date of last gynecologic exam: _____ Pap Smear results: _____

Age of 1st period (menarche): _____ Age of last period (menopause): _____

When did your last period start? _____ What day of your cycle are you on today? _____

Please list any symptoms experienced with menstruation (ex. Cramps, bloating, etc.): _____

_____

Have you been diagnosed with:
❑ Ovarian cysts ❑ PID ❑ Fibroids ❑ Fibrocystic breasts ❑ Endometriosis

Men
Please check all that apply to you within the last 3 months:

❑ testicular pain
❑ history of STD
❑ hernia
❑ prostate problems
❑ increased libido
❑ decreased libido
❑ cold feeling in genitals
❑ painful erections
❑ erectile dysfunction
❑ impotence
❑ difficult ejaculation
❑ discharge from penis
❑ injury to reproductive organs
❑ incontinence
❑ retention of urine
❑ delayed stream
❑ post void dribbling
❑ decreased force of urine stream
❑ currently sexually active

Please check all that apply:

General
- ❑ Insomnia
- ❑ dreams/nightmares
- ❑ Irritability
- ❑ Depression
- ❑ Mood swings
- ❑ Fatigue
- ❑ Poor memory
- ❑ Recent weight loss/gain
- ❑ Cold hands & feet
- ❑ Chills
- ❑ Hot flashes
- ❑ Anxiety

Head & Neck
- ❑ Headaches
- ❑ Migraines
- ❑ Stiff neck
- ❑ Dizziness
- ❑ Fainting
- ❑ Swollen glands

Ears
- ❑ Ringing
- ❑ Hearing loss
- ❑ Infections
- ❑ Hearing aids
- ❑ Vertigo

Eyes
- ❑ Glasses/contact lenses
- ❑ Blurred vision
- ❑ Poor night vision
- ❑ Spots or floaters
- ❑ Eye inflammation
- ❑ Double vision
- ❑ Glaucoma
- ❑ Cataracts

Nose, Throat & Mouth
- ❑ Sinus infection
- ❑ Hay fever/allergies
- ❑ Frequent sore throat
- ❑ Difficulty swallowing
- ❑ Mouth & tongue ulcers
- ❑ Frequent colds
- ❑ Nosebleed
- ❑ Dry nose
- ❑ Nasal congestion
- ❑ Loss of voice
- ❑ Thirst
- ❑ TMJD
- ❑ Facial pain
- ❑ Dry mouth

Skin
- ❑ Hives
- ❑ Rashes
- ❑ Eczema/psoriasis
- ❑ Night sweating
- ❑ Excess sweating
- ❑ Dry skin
- ❑ Easy bruising
- ❑ Changes in moles, lumps
- ❑ Itching

Respiratory
- ❑ Difficulty breathing
- ❑ Difficulty breathing when lying down
- ❑ Wheezing
- ❑ Asthma
- ❑ Chronic cough
- ❑ Cough
- ❑ Coughing up phlegm
- ❑ Coughing up blood
- ❑ Shortness of breath
- ❑ Tight chest
- ❑ Pneumonia

Cardiovascular
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chest pain or tightness
- ❑ Palpitations
- ❑ Rapid heart beat
- ❑ Irregular heart beat
- ❑ Poor circulation
- ❑ Swollen ankles
- ❑ Phlebitis
- ❑ Anemia
- ❑ History of heart attack
- ❑ Heart murmer

Gastrointestinal
- ❑ Nausea
- ❑ Indigestion
- ❑ Stomach pain
- ❑ Gall Bladder disorder
- ❑ Diarrhea
- ❑ Constipation
- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Vomiting
- ❑ Gas
- ❑ Hiccups
- ❑ Acid regurgitation
- ❑ Bloating
- ❑ Bad breath
- ❑ Laxative use
- ❑ Bloody stool
- ❑ Mucus in stool
- ❑ Hemorrhoids
- ❑ Polyps

Musculoskeletal
- ❑ Joint pain/disorder
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Difficulty walking
- ❑ Neck/shoulder pain
- ❑ Upper back pain
- ❑ Lower back pain
- ❑ Rib pain
- ❑ Limited range of motion

Neurological
- ❑ Seizures
- ❑ Tremors
- ❑ Numbness or tingling
- ❑ Paralysis
- ❑ Poor coordination

Genito-urinary
- ❑ Pain on urination
- ❑ Frequent urination
- ❑ Urgent urination
- ❑ Blood in urine
- ❑ Unable to hold urine
- ❑ Incomplete urination
- ❑ Bedwetting
- ❑ Wake to urinate
- ❑ Increased libido
- ❑ Decreased libido
- ❑ Kidney stones
- ❑ Impotence
- ❑ Premature ejaculation
- ❑ Nocturnal emission
- ❑ Pain/itching of genitalia
- ❑ Lumps in testicles

Infection Screening
- ❑ HIV risks: self or partner
- ❑ TB: self or household
- ❑ Hepatitis risk: self or partner
- ❑ History of sexually transmitted disease: self or partner
- ❑ Gonorrhea
- ❑ Chlamydia
- ❑ Syphilis
- ❑ Genital warts
- ❑ Herpes: oral/genital

❑ Other: _____