avanti acupuncture, p.a

Patient Information

Name Date

Home Address

City State Zip Phone

E-mail Address Cell Phone:

Business Address

City State Zip Phone

Occupation

Place of Birth

Date of Birth Age Height Weight Soc. Sec. #

Sex Marital Status (Single, Married, Life Partner, Divorced, Widowed)

In Case of Emergency Notify Phone#

How did you hear of this office?

Have you ever before tried acupuncture or Chinese herbal medicine?

CHIEF COMPLAINT

What are the main health problems for which you are seeking treatment?

Please rate the extent to which your current complaint affects your daily life (1 = minor; 10 = major)

Please rate your commitment to resolving this problem (1 = minor; 10 = major)

What other forms of treatment have you sought?

PAST MEDICAL HISTORY (check all which apply)

- ☐ Allergies
- ☐ Cancer
- ☐ Diabetes
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Seizures
- ☐ Rheumatic Fever
- ☐ Surgeries

☐ Venereal Disease
☐ Vaccinations
☐ Significant Trauma
☐ Thyroid Disease
☐ Childhood Illnesses
☐ Medications
☐ Birth Trauma (see pp. 4-6)
☐ Accidents
☐ Other (please specify)

FAMILY MEDICAL HISTORY (check all which apply and specify which blood relative)

☐ Cancer
☐ Rheumatic Fever
☐ Heart Disease
☐ Tuberculosis
☐ High Blood Pressure
☐ Infectious Disease
☐ Seizures
☐ Other (please specify)
☐ Hepatitis
☐ Diabetes
☐ Emotional Disorder

LIFESTYLE (please indicate the use and frequency of the following)

☐ Coffee
☐ Alcohol
☐ Exercise (please specify type)
☐ Black Tea
☐ Caffeinated Beverages
☐ Tobacco
☐ Recreational Drug

MEDICATIONS

Please list any medications and/or supplements you are currently taking _____

_____

_____

GENERAL HEALTH (please check all that apply)

☐ Poor Appetite
☐ Fatigue
☐ Cold Hands and Feet
☐ Tremors
☐ Strong Thirst
☐ Poor Balance
☐ Cravings
☐ Soft/Brittle Nails
☐ Disturbed Sleep
☐ Poor Coordination
☐ Night Sweats
☐ Large Appetite
☐ Weight Loss
☐ Bruise/Bleed Easily
☐ Chills
☐ Catch Colds Easily
☐ Insomnia
☐ Weight Gain
☐ Cold Abdomen
☐ Localized Weakness
☐ Fevers
☐ Sweat Easily
☐ Sudden Energy Drop
☐ Other (please specify)

SKIN AND HAIR

☐ Rashes
☐ Ulcerations
☐ Psoriasis
☐ Pimples
☐ Itching
☐ Redness
☐ Hair Loss
☐ Recent Moles
☐ Dandruff
☐ Eczema
☐ Hives
☐ Other (please specify)

HEAD, EYES, EARS, NOSE, THROAT

☐ Dizziness
☐ Floaters
☐ Ringing in Ears
☐ Eye Pain
☐ Spots in Eyes
☐ Poor Hearing
☐ Blurred Vision
☐ Night Blindness
☐ Earaches

- ☐ Headaches
- ☐ Migraines
- ☐ Recurrent Sore Throats
- ☐ Sores on Lips/Tongue
- ☐ Dry Mouth/Throat
- ☐ Bleeding Gums
- ☐ Nosebleeds
- ☐ Facial Pain
- ☐ Jaw Clicking
- ☐ Toothaches
- ☐ Other (please specify)

CARDIOVASCULAR

- ☐ Dizziness
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Fainting
- ☐ Cold Hands/Feet
- ☐ Chest Pain
- ☐ Swelling of Hands/Feet
- ☐ Blood Clots
- ☐ Difficulty Breathing
- ☐ Palpitations
- ☐ Other (please specify)

RESPIRATORY

- ☐ Cough
- ☐ Coughing Blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Coughing Phlegm
- ☐ Pain with deep breath
- ☐ Shortness of Breath
- ☐ Nasal Congestion
- ☐ Difficulty breathing when lying down
- ☐ Other (please specific)

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Bloating
- ☐ Belching
- ☐ Abdominal Pain/Cramps
- ☐ Indigestion
- ☐ Heartburn/Reflux
- ☐ Retention of Food in Stomach
- ☐ Lack of Appetite
- ☐ Excessive Appetite
- ☐ Rectal Pain
- ☐ Black Stools
- ☐ Blood in Stool
- ☐ Hemorrhoids
- ☐ Bad Breath
- ☐ Sensitive Abdomen
- ☐ Chronic Laxative Use
- ☐ Other (please specify)

GENITO-URINARY

- ☐ Pain on Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Urgency to Urinate
- ☐ Unable to Hold Urine
- ☐ Kidney Stones
- ☐ Decrease in Urine Flow
- ☐ Impotence
- ☐ Sores on Genitals
- ☐ Waking at Night to Urinate
- ☐ Other (please specify)

REPRODUCTIVE/GYNECOLOGICAL

- Age of 1st Period _____
- Age at menopause _____
- # Pregnancies _____
- # Live Births_____
- # Premature Births _____
- # Miscarriages/Abortions ___
- # days between periods _____
- # days of flow _____
- Color of blood _____
- ☐ Clots (Color _____)
- ☐ Painful Menses
- ☐ Irregular Menses
- ☐ Premenstrual Symptoms
- ☐ Strong Menstrual Odor
- ☐ Vaginal Discharge
- ☐ Vaginal Odor
- ☐ Vaginal Dryness
- ☐ Fibroids
- ☐ Breast Lumps/Swellings
- ☐ Endometriosis
- ☐ Ovarian Cysts
- ☐ Sexually Transmitted Disease
- ☐ Urinary Tract Infection
- ☐ Hot Flashes

☐Decreased Sex Drive ☐Positive Mammogram/Pap Smear ☐Other (please specify)

MUSCULO-SKELETAL

☐Neck Pain ☐Back Pain ☐Knee Pain
☐Muscle Pain ☐Foot/Ankle Pain ☐Shoulder Pain
☐Hip Pain ☐Hand/Wrist Pain ☐Sciatica
☐Muscle Weakness ☐Other Joint/Bone Problems (please specify)

NEURO-PSYCHOLOGICAL

☐Seizures ☐Dizziness ☐Loss of Balance
☐Areas of Numbness ☐Poor Memory ☐Lack of Coordination
☐Concussion ☐Depression ☐Anxiety
☐Bad Temper ☐Easily Stressed ☐Attempted Suicide
☐Treated for Emotional Problems ☐Other (please specify)

Because an acupuncture physician must be aware of existing physical conditions, I have stated all known medical conditions and take it upon myself to keep the acupuncture physician updated on my physical, mental, and emotional health.

Signature: _____ Date: _____