Patient Information Form **Date:_____**

Name_____
(First) (Last)

Home Address _____
(Street, Apt #) (City) (State) (Zipcode)

Home Ph (___)_____ Work (___)_____ Cell (___)_____

Phone Number that we can leave you a message _____

E-Mail _____ Age _____ Occupation_____

Weight _____ Height _____ Gender: F____M____

Birthdate___/___/_____ Allergies _____

Single___Married___ Divorced___ Seperated___Widowed____Paternership_____

Emergency Contact _____ Relationship to You_____

Emergency Contact Phone Number_____

Who Referred You to Acupuncture & Herbal Solutions_____

Have you ever had Acupuncture before? YES_____ NO_____

AHS Confidential Patient Information Sheet

Men:

__ Impotence
__ Vasectomy/ Date: _____
__ Prostate problems

Women:

Are you pregnant right now? __ Yes __ No __ Trying __ Maybe
Method of Birth Control: _____
Age at first period: _____
Date of last menses: _____
Age at menopause: _____
# of Pregnancies: _____ Births: _____ Abortions: _____ Miscarriages: _____ Hysterectomy: __ Yes __ No Date:_____
Typical length of cycle (days): _____
__ Clotting __ Painful Periods
__ Heavy Flow __ Scanty Flow

__ Low libido/Excessive libido
__ Painful Intercourse

__ Bleeding Between Cycles
__ Irregular Cycles
__ Vaginal Discharge
__ Breast Lumps/Tenderness
__ Nipple Discharge __ Infertility
__ Menopausal Symptoms
__ Premenstrual Problems
__ Low libido __ Excessive libido
__ Painful Intercourse

Medications & Supplements: Please list all the prescription and over the counter medications you are currently taking:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Lifestyle (Daily amount used within the past 2 months)

Tobacco: __ Yes __ No Amount: _____
Alcohol: __ Yes __ No Amount: _____
Coffee: __ Yes __ No Amount: _____
Do you skip meals on a regular basis? __ Yes __ No
Are you a vegetarian or vegan? __ Yes __ No

Health Inventory

Cardiovascular
__ Heart Disease
__ A Pacemaker
__ High BP
__ Low BP
__ Chest Pain
__ Palpitations
__ Stroke
__ Varicose Veins
__ Edema

Energy & Immunity:
__ Chronic Fatigue Syndrome
__ General Fatigue
__ Slow Wound Healing
__ Easy Bruising
__ Chronic Infections
__ Frequent Allergies

Colds
__ Difficulty Breathing
__ Emphysema
__ Persistent Cough
__ Pleurisy
__ Tuberculosis
__ Shortness of Breath

Neurological:
__ Vertigo/ Dizziness
__ Paralysis
__ Numbness / Tingling
__ Loss of Balance
__ Seizures/ Epilepsy
__ Dyslexia

Emotional / Mental:
__ Clinical or Mild Depression
__ ADD or ADHD
__ Mood Swings
__ Nervousness
__ Anxiety/ Panic Attack
__ Alzheimer's
__ Dementia
__ Poor Memory

Respiratory:
__ Emphysema
__ Pneumonia
__ Asthma
__ Cough
__ Frequent Colds
__ Shortness of Breath

Genito-Urinary Tract:
__ Kidney Disease
__ Kidney Stones
__ Painful Urination Urination
__ Frequent UTI
__ Frequent Urination
__ Blood in Urine
__ Incontinence

Gastrointestinal:
__ Stomach Ulcers
__ Changes in Appetite
__ Nausea/Vomiting
__ Abdominal Pain
__ Constipation/ Diarrhea

Head, Eye, Ear, Nose & Throat:
__ Impaired Vision
__ Glaucoma
__ Glasses/Contacts
__ Tearing or Drying
__ Impaired Hearing
__ Ear Ringing
__ Earaches
__ Ear Infections
__ Headaches
__ Sinus Problems
__ Nose Bleeds
__ Teeth Grinding
__ Frequent Sore Throats
__ TMJ

Abdominal Pain
__ Gas
__ Heart Burn
__ Belching
__ Gall Bladder Disease/ Stones
__ Hemorrhoids
__ Constipation
__ Diarrhea

Musculo-Skeletal:
__ Neck / Shoulder Pain
__ Muscle Spasms/Cramps
__ Arm Pain
__ Upper Back Pain
__ Mid Back Pain
__ Low Back Pain
__ Leg Pain
__ Osteoporosis
__ Arthritis
__ Joint Pain

Endocrine:
__ Hypothyroid
__ Hypoglycemia
__ Hyperthyroid
__ Diabetes
__ Night Sweats
__ Unusual Sweating
__ Feeling Hot or Cold

Other:
__ Hepatitis A, B, C
__ Cancer
Type:_____
__ Fibromyalgia
__ Lupus
__ Herpes
__ HIV
__ Rashes / Eczema / Hives
__ Lyme Disease
__ Substance Abuse
__ Hemophilia
__ Thin / Graying hair
__ Areas of Pain
_____
_____
_____